

Roy Collins.

THE PRIMARY HEALTH CARE TEAM

**REPORT OF A JOINT WORKING GROUP
OF THE STANDING MEDICAL ADVISORY COMMITTEE
AND THE STANDING NURSING AND MIDWIFERY ADVISORY COMMITTEE**

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REPORT OF THE JOINT WORKING GROUP ON THE PRIMARY HEALTH CARE TEAM

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PART I - INTRODUCTION AND BACKGROUND

Introduction

1. The Joint Working Group was set up by the Standing Medical Advisory Committee (SMAC) and the Standing Nursing and Midwifery Advisory Committee (SNMAC) towards the end of 1978 because of their growing awareness that in some areas belief in the concept of the primary health care team was waning. In particular, concern focused on reports that nurse attachment arrangements in a number of health authority areas, particularly in inner city areas, had been or were being dismantled because of problems of providing adequate nursing care to the community as a whole, or for reasons of economy. Since co-operation between health visitors, district nurses and general medical practitioners (GPs) is the basis for effective team-working in primary health care, this was considered a very real threat to the concept of the primary health care team.

2. We were given the following terms of reference:

"to examine problems associated with the establishment and operation of primary health care teams and to recommend solutions."

3. Our Group consisted of 3 medical members nominated by SMAC and 3 nursing members nominated by SNMAC:

Dr Wilfrid G Harding, CBE, FRCP, FFCM, DPH - Chairman
Miss W Frost, OBE, SRN, SCM, HV Cert, QN - Vice Chairman
Mrs E Allison, SRN, NDN Cert, PWT, RCNT, FET Cert
Miss S A Jack, BA, SRN, SCM, HV Cert, QN, RNT, HVT
Dr E V Kuenssberg, CBE, MB, ChB Ed, FRCGP
Dr G Murray Jones, OBE, MBE (Mil), MRCS, LRCP FRCGP

We had the benefit of help from observers from the Department of Health and Social Security (DHSS):

Dr M Hatton (Senior Medical Officer)	(until December 1979)
Dr D C Ower, TD (Senior Principal Medical Officer)	(from January 1980)
Dr W G Griffiths (Medical Officer)	(from January 1980)
Miss D Harding (Nursing Officer)	(until February 1979)
Miss S G Earl (Nursing Officer)	(from March 1979)
Mr R P S Hughes	(until December 1978)
Miss M E Stuart	(from January 1979)

and secretarial services were also provided by the Department:

Mr D A Martin (Secretary)
Miss K Doran (Assistant Secretary until May 1979)
Mr S D Catling (Assistant Secretary from June 1979)

4. Throughout its existence the Joint Working Group operated as one body in which the Group's advisers from within the Department and its secretariat gave unstinting and most effective support. We owe special thanks to the secretariat: Mr Martin, Miss Doran and Mr Catling. All of us had high expectations for their standard of service because of our previous experience in similar groups, but even against this background we were deeply impressed by their enthusiasm, by their understanding and by their unfailing attention to all our needs.

The Group's Task

5. Our terms of reference and our own professional backgrounds mean that we have confined our attention to what might be called the "core team", ie the GP, health visitor, district nurse⁺, midwife and other nursing staff including practice nurses^{*}. We also included the GP's secretary and/or receptionist because of the important role she performs in respect of all the other members of the team. We have not been able to consider the substantial contribution to primary health care that is provided by social workers, clinical medical officers, community psychiatric nurses, dentists, pharmacists, chiropodists and others. This has been criticised, but extending our remit would have meant a larger group and a more extended timescale, and it was thought important to consider first the problems of the "core team". Nevertheless because of the considerable implications of the parallel provision of child health services by means of clinics in many places we gave some consideration to the implications of this for primary health care teams.

6. In our request for evidence we therefore adopted the following definition of the primary health care team:

"A primary health care team is an interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service."

+ In referring to district nurses the following staff are included: State Registered Nurses (SRNs) with District training (who have equivalent grading and responsibility to ward sisters in hospitals and will lead the district nursing team within the primary health care team), SRNs without District training, State Enrolled Nurses (SENs) with and without District training, and any other qualified nurses employed by the health authority to assist the district nursing service.

* In referring to "practice nurses" here and in the rest of our Report we are referring to those nurses employed directly by GPs to provide services as required by them and thus working outside the professional and managerial nursing structure provided for nurses employed by health authorities.

The comments we received indicated that this definition was considered by some to be idealistic and by others to be too limited. Clarity and understanding of roles and the identification of a shared common purpose are problem areas for many, perhaps most, of the primary health care teams functioning today. Nevertheless many are working effectively, but they are perhaps not as successful as they could be. We recognise that the definition also begs the question of what constitutes "an effective primary health care service" but evaluation of this is very difficult. The diversity of primary health care has led to many different interpretations and hence working arrangements for teams. There is a need to clarify the administrative workings of "core teams" in order to see how true co-operation and common interest in the care of the patient can be achieved.

7. We were also anxious to establish, if at all possible, whether patients and the community at large had any views on primary health care provision by teams or in other ways. We were not surprised that it proved extremely difficult to elicit patients' views on organisational aspects, because patients, on the whole and understandably, tend to judge the quality of the primary health care service they receive according to their experience of contact with the particular team members directly responsible for their care and treatment, and not against the background of the organisational pattern which underlies it. Nevertheless although our Report is mainly concerned with organisational matters, we have kept in the forefront of our minds throughout our work the fact that the patient is the *raison d'être* of the team, and that quality of patient care is the most important measure of success.

8. Our first meeting was held on 3 November 1978, and we met on a total of 14 occasions, including one weekend meeting. We sought evidence by:

- sending a consultation letter to health authorities and to relevant professional organisations asking for specific information and views on problems encountered;
- preparing and issuing a questionnaire to be completed by GPs and primary health care nursing staff of 3 selected Area Health Authorities (AHAs) (this was intended as a pilot trial for a wider survey, but as explained below was not pursued);
- appealing for evidence from individuals via letters in professional journals; and
- taking oral evidence.

We received a considerable body of evidence from a wide range of people involved in providing, receiving and studying primary health care services and we wish to express our gratitude to all of those who helped us. A list of those who submitted evidence is appended at Annex 1.

9. We first looked at the available statistics to see how far these gave an indication of the trend in the development of primary health care teams and of the development of attachments in particular, but we did not find these helpful. Information on attachment is not collected centrally; there is therefore no "hard" information about trends. We attempted to

gather some up-to-date information of our own via a questionnaire which we piloted in 3 AHAs (Humberside, Hampshire, and Sutton, Merton and Wandsworth); this illustrated the difficulty of collecting comparable information on these topics. The aim of the questionnaire was to provide a statistical profile of primary health care teams currently working in the National Health Service (NHS), but from the information obtained it was clear that a wide variety of arrangements are described as "primary health care teams" - a problem which we discuss later in the Report - and there were significant problems in defining attachment in a way which resulted in comparable information being obtained. The responses to the questionnaire were however very useful to us in that they confirmed, in a slightly different form, the information we derived from other sources.

10. We are aware of research studies, past and present, which include information on attachment; eg the survey which the Office of Population Censuses and Surveys (OPCS) is carrying out on behalf of DHSS of nurses working in the community, the results of which may be very helpful since it includes questions on attachment. We also took note of a number of research studies of the health needs of declining urban areas and problems associated with providing health care in such areas.

11. While we consider that there is sufficient evidence of the merits of teamwork for there to be no doubt about it being the best organisational basis for primary health care, there is room for further investigation of the various ways in which teamwork can be achieved, and of the factors involved. We considered whether to recommend the creation of one or more Institutes of Primary Health Care to carry out this work and monitor progress in primary health care for delivery generally, but most of us felt that such a move would not be appropriate at the moment, and might, indeed, conflict with any policy to strengthen academic Departments of General Practice in medical schools. It may however be appropriate to organise a series of primary health care case studies within a particular geographical area which exhibits a wide range of different conditions affecting the way in which primary health care is provided.

The Development of Primary Health Care and the Team Concept

12. In recent years, there has been a growing emphasis on primary health and on methods of achieving the team approach in the provision of such care. Advances in medical technology and pharmacology have meant that an increasing amount of illness can be dealt with mainly or wholly in the community, while at the same time the emergence of nursing as an independent profession coupled with more advanced training in the clinical aspects of nursing care has facilitated the development of the primary health care team to provide co-ordinated comprehensive care in the community.

13. In 1963 the report of a sub-committee of the Standing Medical Advisory Committee of the Central Health Services Council, "The Field Work of the Family Doctor" ¹⁺ (Chairman Dr Annis Gillie) recommended that:

+ References are listed in Annex 2.

"Field workers such as the nurse, midwife and health visitor should be attached to individual practices".

Then in 1967 a jointly-sponsored conference* at the Wolfson Institute² - "Family Health Care - the Team" brought together many members of the medical and nursing professions responsible for providing primary health care services in a 2-day symposium devoted to the exploration of the role of the team and its part in the future development of primary health care. The success of this conference was reinforced in 1969 by the recommendations of the Social Science Research Unit in "Study No 1. Nursing Attachments to General Practice" which concluded:

"The advantages of collaboration between general practitioners and LHA nursing staff easily out-weigh any disadvantages".³

14. With the publication in 1971 of "The Organisation of Group Practice"⁴ a report of a sub-committee of the Standing Medical Advisory Committee (Chairman: R Harvard Davis), the development of primary health care teams was further advanced. The report recommended:

"Much of the medical work required in the community can be undertaken by the basic unit (this is defined as a doctor supported by nurses and secretarial staff) caring for a defined population. This basic unit will preserve the important features of personal care, and, of almost equal importance, secure good communication within the team".⁵

15. After the publication of "The Organisation of Group Practice" references to the "primary health care team" are frequently found. The Annual Report of the Chief Medical Officer of DHSS for the year 1972 describes the development of increasing numbers of "Health Teams" and records the substantial increases in attachment of health visitors and district nurses to general practices.⁶

16. The statutory professional training bodies for the various professions involved have also made significant contributions to the development and wider dissemination of the team concept. For example the Council for the Education and Training of Health Visitors (CETHV) organised multi-disciplinary seminars in 1972, 1973, 1974, 1976, and 1977, and in July 1979 a 2½ day Symposium was organised jointly by the CETHV, the Central Council for Education and Training in Social Work, the Panel of Assessors for District Nurse Training and the Royal College of General Practitioners (RCGP) to consider problems associated with team work and their possible resolution by means of inter-professional training.

* The sponsors were: the Health Visitors Association, the National Association of State Enrolled Nurses, the Queen's Institute of District Nurses, the Royal College of General Practitioners, the Royal College of Midwives, the Royal College of Nursing, and the Society of Medical Officers of Health. The conference was chaired by Dr Annis Gillie, then President of the RCGP.

17. In 1974 the term "primary health care" appeared for the first time in the Annual Report of the DHSS.⁷ The Report announced:

"The aim is to create primary health care teams in which general medical practitioners, home nurses, health visitors and in some cases social workers and dentists, work together as an interdisciplinary team, thus facilitating co-ordination and mutual support in the planning and delivery of care".

18. The Consultative Document "Priorities for Health and Personal Social Services in England" issued in 1976 proposed that:

"Emphasis should be given to encouraging the development of primary health care teams".⁸

Expenditure on primary care services as a whole was planned to rise by 3.8 per cent a year; of this expenditure over 95% is on the Family Practitioner Services, then forecast to grow at 3.7% annually. For district nurses and health visitors employed by health authorities, the national growth rate was to be 6% a year. It was thought that:

"this should lead to a considerable development of primary health care teams".⁹

19. There have also been a number of publications in recent years which have examined the work of the team in relation to primary health care, including Miss L Hockey's "Feeling the Pulse"¹⁰ and "Care in the Balance"¹¹ in relation to the nursing role; Gilmore, Bruce and Hunt's analysis of the team concept in primary health care in "The Work of the Nursing Team in General Practice"¹²; Dr P Pritchard's "Manual of Primary Health Care"¹³; and Donald Hick's "Primary Health Care: a review".¹⁴

20. A number of other major policy documents in the health field have also included references to primary health care teams; the Report of the House of Commons Expenditure Sub-Committee on Preventive Medicine,¹⁵ the White Paper "Prevention and Health"¹⁶ and the report of the Royal Commission on the NHS¹⁷ ('the Royal Commission') all stressed the importance of the primary health care team in general and also commented on the team's importance in the promotion of preventive and health education activities. At the same time the past few years have seen the publication of a number of important reports of committees looking at the needs of particular groups of people - children, mentally handicapped people etc - which have implications for the growth and development of primary health care. These include the Court,¹⁸ Warnock,¹⁹ and Jay²⁰ Reports. The eventual implementation of all or part of the recommendations made in these Reports will have important implications for the future work of primary health care teams.

21. In our Report we examine problems which have occurred and which are occurring in relation to training, role and status, but we have confined ourselves to the position in this country which, in these matters, can no longer be seen as an island. There are now influences from the continent

of Europe and these are likely to increase in the future. Already a number of Directives have been issued in relation to training and free movement of staff with which we must comply, and this and the increased exchange of ideas which will result from our closer relationship with our European colleagues have considerable implications for the development of primary health care in this country. Indeed the pilot studies we suggest in paragraph 11 may well have application beyond the United Kingdom and, in view of that, might well merit European Community funding.

PART II - PROBLEMS AND RECOMMENDATIONS

CHAPTER 1 - INTRODUCTION

1.1 In this part of our Report we present and analyse the problems which have been brought to our attention by those submitting written and oral evidence, and make a number of recommendations about measures to alleviate the problems identified.

1.2 One fundamental problem is the wide variety of meanings attached to the term "primary health care team". Some of the comments we received began by proposing alterations to the definition we had adopted (quoted in Part I paragraph 6) - one or two rejecting it altogether as too inflexible and idealistic to be useful. The amount and strength of reaction to it illustrates both the variety of interpretations that can be placed on the term and the difficulty of defining it in a way that is universally acceptable. The concept of teamwork has been popular throughout the health service for some years, eg Area and Regional Teams of Officers, teams in psychiatry, operating theatre teams and so on, and like all fashionable and hardworked concepts, its meaning and precise reference are somewhat blurred.

1.3 This lack of a generally agreed perception of the primary health care team often relates closely to the different professional viewpoints of those involved - one example being the extent to which the GP's and the health visitor's perception of the main objectives of the team are frequently influenced by their different training and professional orientation. Alternatively the individual members of the team may place different emphases of the four main functions of teamwork - preventive, diagnostic, therapeutic, and caring - although all will be involved in each of these to varying extents. Two different ways of looking at the "team" were suggested: the team could be seen primarily as a means of co-ordinating services to provide a communication network for a group of professionals with overlapping responsibilities; or in terms of a "patient-oriented" team whose precise membership and function would be determined by the task in hand at any given time. There are other ways of looking at the primary health care team. Each may be equally valid if all the members of the team subscribe to it. Indeed the conscious adoption of a particular model may help develop effective teamwork, provided that the need for flexibility and change in response to changing circumstances is acknowledged. Subscribing to a particular view of the team is not, of course, in itself enough. It must be carried through into everyday practice. Some teams only masquerade as such and continue operating as individuals without any dialogue or consultation.

1.4 However, despite the fundamental uncertainty about precisely what primary health care teams are and what they should do, few of those submitting comments to us had difficulty in identifying the main problem areas. We were impressed by the quality and spread of these comments, and by the high degree of consensus about the identity and nature of the major problems. Within this consensus, however, it was noticeable that there were broadly two main viewpoints; that of the nurses and that of the GPs. This is to a degree inevitable - given the different backgrounds, training, structure, and experience of the two groups - and indeed has been a factor in our own deliberations. This in itself illustrates a potential source of problems, as does the further difference of orientation within the nursing group itself between the district nurses' role of caring for "sick" people and the health visitors' role which includes advising and educating predominantly "healthy" people. Each of these groups is in turn divided into "optimists" and "pessimists" - those who see the problems as minor irritants in an otherwise effective service, and those who consider that primary health care teams cannot work effectively until the problems are solved - but again despite differences of viewpoint there was a general consensus about the importance of co-operative working to overcome difficulties.

1.5 One area in which there was a marked lack of consensus, however, was the question of whether the primary health care team concept was being applied effectively and successfully in the NHS. In our consultation letter we explained that our Group had been formed because of indications that "in some areas belief in the primary health care team concept is waning". Several of those commenting responded quite indignantly to this suggestion; eg "In this District the primary health care team concept is not on the wane, it is considered to be a vitally necessary development". Others took the view that in their District or Area the concept had never got off the ground, and indeed was considered to be a myth!

1.6 However there was considerable support for the view that whilst primary health care teams were the ideal way to provide effective primary health care services, the ideal might not yet be practicable within the constraints imposed by lack of resources and deficient staffing levels. Comments were also made about the difficulty of establishing effective teams in the face of organisational difficulties, such as a high proportion of "single-handed" GPs, or considerable numbers of people not registered with GPs.

1.7 It may be that the clear advantages to be gained from providing primary health care services on the basis of teams when adequate numbers of staff are available have blinded people to the problems likely to be encountered where conditions are not favourable - until, that is, the teams have been set up and are seen to be running into difficulties. If the team "fails" the members may blame themselves for not being able to make it work as others have done. They may not recognise the more fundamental external reasons for failure.

1.8 The comments we have received indicate three fundamental problem areas which seem to provide the basis for a wide range of subsidiary problems:

i. lack of resources, including inadequate premises, can make it difficult for teams to work effectively. The unevenness of distribution of nursing staff, and in particular of health visitors, means that in some areas established teams may be unacceptably stretched and members at risk of losing their self-confidence and credibility with patients and fellow professionals. The need to make economies increasingly leads to the temporary or permanent re-allocation of district nursing or health visitor duties, often at short notice, which makes true attachment impossible. (See chapter 2).

ii. the effectiveness of the team depends to a large extent on mutual understanding and respect for the different orientations and changing roles of the team members. In particular, problems frequently seem to have arisen from the fairly rapid changes that have occurred in the role of nurses, and in their professional status. GPs do not always understand or accept these changes. (See chapter 3).

iii. the primary health care team attempts in its management and organisation to straddle two very different systems:

- independent contractors - GPs - who can employ their own staff
- a separate professional structure which forms part of much wider and more complex management arrangements - nurses, health visitors and midwives employed by health authorities. (See Chapter 4)

1.9 Finally there are particular geographic locations - mainly inner urban and isolated rural areas - in which these problems may be exacerbated by particular environmental and socio-economic factors. (See Chapter 5)

CHAPTER 2

RESOURCES FOR PRIMARY HEALTH CARE

2.1 Comments showed that there is a general feeling that since NHS reorganisation in 1974, and despite the publication of the Consultative Document on Health and Personal Social Services Priorities 21, "The Way Forward" 22 and other exhortations at national level, the provision of hospital services remains the priority so far as the allocation of resources is concerned and that at a time of financial constraints it becomes increasingly difficult for community health services to maintain their share of the budget. The solutions suggested to remedy this and present more forcefully the case for priority for community health services ranged from the introductions of centrally determined budgets for community health services, to the suggestion that those involved in providing these services should seek greater publicity for the effects of financial difficulties on patient services.

2.2 There has been an increasing emphasis on primary health care in recent years. More and more tasks are being placed upon primary health care staff as a result of earlier discharges from hospital; increased day surgery; early transfers of maternity cases from hospital to home after hospital delivery; greater emphasis on care in the community for children, the elderly, the mentally handicapped and mentally ill; and on prevention. The two priorities' documents made clear the importance of strengthening community services. The Priorities' Document published in 1976 said that emphasis should be given, inter alia, to:

"encouraging the development of primary care teams and, where necessary, to encouraging a better distribution of manpower. The proposal to maintain a relatively large health centre capital programme should assist in this".
23

It was also suggested that there should be a 6% per annum increase in national expenditure on health visiting and home nursing services.

2.3 The financial climate since those documents were issued has not, however, been conducive to any significant shift in resources from one sector to another - not to expansion. Expenditure on health visiting services rose by only 7.5% over the four years between 1975/6 and 1979/80 at an average annual growth rate of only 1.8% and expenditure on district nursing services rose by 19.2% over the same period, at an average annual rate of 4.8%. The expenditure totals at constant price levels for the different years are shown below (comparable figures are not available for earlier years).

<u>Expenditure: £million at constant 1980 prices - England</u>					
	<u>1975/6</u>	<u>1976/7</u>	<u>1977/8</u>	<u>1978/9</u>	<u>1979/80</u>
<u>Health Visiting services</u>	66.2	66.0	69.9	70.9	71.2*
<u>District nursing services</u>	114.5	123.8	125.1	131.3	136.5*
*1979/80 figures are provisional.					

2.4 Both health visiting and district nursing services have increased considerably over the last decade, though from a small base; there has been a 41.5 increase in the whole-time equivalent (wte) number of health visitors in the primary health care nursing service (from 5729 in 1970 to 8111 in 1979) and a 59.5 increase in wte district nurses (from 8609 in 1970 to 13738 in 1979). Nevertheless, the total numbers are still small and there is considerable local variation. The targets ratios set by the Department in 1972²⁴ have not yet been met nationally for health visitors and although the district nurse ratio was reached nationally in 1974 the range of ratios locally gives cause for concern. The following table illustrates the position as at 1979, the latest year for which figures are available.

HEALTH VISITORS: 1979 - ENGLAND

Recommended target ratio	National average	'Best'	'Worst'	Number of AHAs with:-			
				1:0-3999	1:4-4999	1:5-5999	1:6000+
1:4300*	1:5150	1:2879	1:7358	4	36	34	16

*1:3000 in areas with highly developed attachment schemes or high immigrant populations

DISTRICT NURSES: 1979 - ENGLAND

Recommended target ratio	National average	'Best'	'Worst'	Number of AHAs with:-			
				1:0-2999	1:3-3999	1:4-4999	1:5000+
1:4000*	1:3377	1:2211	1:5638	18	59	12	1

*1:2500 in areas with extensive attachment schemes or a high proportion of elderly and/or disabled people.

(The recommended target ratios were promulgated in 1972, but the suggested ratio of one health visitor to 4300 population was originally suggested in the Jameson Report²⁵ as long ago as 1956 and includes health visitors working in the school health service. The district nursing target ratio includes SRNs and SENs with and without district training but excludes SRNs and SENs assisting home nursing services and auxiliaries employed in support of these services).

2.5 In any case the recommended ratios must now be considerably out of date in view of the reduction in nurses' working hours and increases in holidays and time spent on training courses. In view of the large number of AHAs with very low nursing staff ratios, particularly in the case of health visitors, it is hardly surprising that attempts at team-working do not always run entirely smoothly. We discuss this further in Chapter 4.

2.6 Another factor may be the size of the GP's list; the Royal Commission noted the increase in the number of GPs over the last decade and the concomitant decrease in average list sizes and remarked, in response to the "New Charter" ²⁶ proposal to decrease the average list size further to 1700, that:

"little is known which would help to determine an optimum range of (list) sizes. Consultation time could be extended either by increasing the numbers of GPs, and thus reducing average list size, or by increasing the numbers of other professions who work with GPs and delegating more of the GPs' work to them. We recommend that before a maximum or minimum list size is adopted, considerable research on this important question should be undertaken." ²⁷

We agree that more research is needed in this area and welcome the importance which the Royal Commission attach to it.

2.7 We recognise that a number of factors combine to make an increase in the pressure of work for primary health care staff, in particular health visitors and district nurses, inevitable over the next 10-20 years. These are:

- increasing numbers of elderly; there will be a 5% increase in the 65+ age group by 1986 and a 20% increase in the 75+s. By 1996 there will be 60% more people over 85 than there are now.
- the rising birth rate, which, after a considerable decline, is predicted to lead to an increase of over 10% in the 0-4 age group by the mid-1980s.
- the policy of high throughput for hospital patients which leads both to more patients being dealt with and to a greater need for after-care and continuation of rehabilitation in the community.
- the increase in the number of surgical procedures carried out on a day basis which involve increased demand for high-dependency after-care in the community.
- the increasing emphasis on care in the community for a variety of care groups (the elderly, children, the mentally handicapped, mentally ill and physically disabled).
- the increasing emphasis on home care for the terminally ill.
- increased public expectations.
- cultural changes - greater mobility, weakening familial ties, more one-parent families and increasing needs of ethnic minorities - all of which increase the need for support and health education in the community.

2.8 These trends are likely to place even greater strain on effective teamwork, whilst making it even more important. We are also concerned that even the fairly modest rate of increase in the numbers of nursing and health visiting staff for the years immediately following NHS reorganisation in 1974 may not be maintained as secondments to health visitor and district

nurse training have more recently tended to drop, as illustrated by the table below:

	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
<u>Candidates for</u> <u>district nursing</u> <u>examinations</u> <u>(SRNs and SENs)</u>	2010	2020	2027	1864	1872	1875
<u>Level of intake -</u> <u>Health visiting</u> <u>training courses</u>	1069	1236	1160	1067	1134	1100

We fear that in times of difficulty for the NHS the community health services' voice is not a strong one in obtaining an appropriate share of limited resources. This is partly because of the sheer strength of the "hospital voice" in the medical, nursing and administrative fields; thus the vast majority (some 90%) of nurses work there and all top nursing management have hospital experience, whereas only a minority have community experience. It is also due to the difficulty of reallocating money to expand services when savings may need to be made at the expense of an existing service. There is no doubt that the closing of wards and hospitals and the lengthening waiting lists are more tangible phenomena than, for example, a reduction in home visits by health visitors, district nurses and midwives which may leave vulnerable groups - especially children and the elderly - at risk; the closure of antenatal clinics; or lengthening waiting time for nursing aids such as hoists, walking aids, air beds etc. Nevertheless the inability of the services in the community to cope in an effective way with their increasing workload could have very serious results for patients and their families, for the rest of the NHS (eg hospital stays may need to be longer) and for the community at large (slower return to employment, greater risk of permanent disablement and failure to prevent prolonged or permanent institutional care).

2.9 In times of financial constraint there is a tendency to look for quick and tangible savings; wards, units or even hospitals may be closed either temporarily or permanently. Before such action is taken we consider it essential that authorities should study the likely effect on primary health care services and take these fully into account in their decisions. Some provision for extra support in the community is likely to be required to meet the needs of those patients who are no longer able to obtain hospital treatment.

2.10 The comments which we have received leave us in no doubt that teams in some areas are at present working under considerable difficulties in trying to provide an effective service and proper coverage and we think it essential that some allowance for increasing pressures be made. We therefore welcome the specific endorsement by the Royal Commission of the priority given by the Department to the continued expansion of the district nursing and health visiting services ²⁸ and we consider that health authorities should make every effort to ensure that this leads to a real increase in the resources made available for the expansion of these services and not just a routine endorsement of their importance without any practical result.

2.11 WE RECOMMEND THAT

- i. the target ratios of health visitors and district nurses to population should be updated to take account of changes in working hours, holiday entitlement, training requirements, etc;
- ii. all authorities with ratios below the old targets should be encouraged to increase their staffing to this level as soon as possible;
- iii. authorities with 'inner city' problems should take urgent action to reach the ratios suggested for areas with particular problems (though we appreciate the difficulties which are discussed in Chapter 5);
- iv. continued priority should be given to expanding health visiting and district nursing services; and
- v. no further closure of or restrictions on in-patient facilities, or the introduction of a new early-discharge policy, should be undertaken without consideration of and consultation about the likely consequences for primary health care services.

2.12 Most of those commenting on the question of resources, however, made the point that even improvements in the level of resources available in primary health care, or in the quality of practice premises or other resource related aspects, would not guarantee success, unless the fundamental problems of inter-personal relationships and management of the team, described in more detail in succeeding chapters are resolved. Although we consider that a really good team can overcome some of these difficulties, providing there is administrative flexibility, there is considerable risk in expecting teams to "muddle through" without adequate resources; if team members are deprived of the tools with which to do their job properly, frustration may well set in, and the team's effectiveness may be seriously reduced no matter how dedicated, well-motivated and integrated they may be.

Premises

2.13 By far the most frequently mentioned "tools for teamwork" in the comments we received were the premises from which the team work. There was agreement that the team should, wherever possible, work "under the same roof" and many considered that where this was not the case the team concept was a non-starter. A considerable number of those commenting put forward the view that health centres provided the optimum accommodation for the team - stressing the need to avoid institutional and impersonal designs and generally endorsing the idea of smaller rather than larger health centres - but others pointed out that teams could function just as well from well designed privately provided practice premises, and that use of the latter gave GPs unwilling to enter health centres the opportunity to become involved in teams.

2.14 Problems raised were generally in two categories; lack of space and poor design, the former more often raised in respect of privately provided premises, the latter in relation to health centres.

Problems relating to lack of space included:

- i. no space available for nurses, health visitors and midwives to store records and equipment;
- ii. insufficient space to enable nurses, health visitors and midwives to carry out essential administrative and clerical tasks, even on a shared basis;
- iii. lack of accommodation suitable for use as a treatment room or for health education;
- iv. no common-room facilities to encourage informal contact and communication;
- v. no space available for formal meetings of the team;
- vi. insufficient space for car parking close to the practice premises;
- vii. insufficient room for accommodation of students, both medical and nursing, or for teaching;
- viii. lack of privacy for health visitors' interviews with patients; and
- ix. inadequate accommodation for special sessions, especially developmental assessment and child health clinics.

2.15 Complaints about inadequate design included:

- i. GPs' surgeries and nurses' facilities in health centres were often badly located, in extreme cases on separate floors with other AHA-employed staff in intervening offices. This tends to minimise informal contact and so limits the effectiveness of communication and the growth of a corporate identity for the team. Gilmore, Bruce and Hunt noted a significant correlation between proximity of offices and frequency of informal contact between team members. 29
- ii. large common waiting rooms serving several teams were noted as unpleasant for both patients and team members, and a frequent source of confusion if several teams' records were stored together at a single receptionists' desk;
- iii. the existence of basic design faults, which reduced the effectiveness of the premises vis-a-vis the provision of adequate levels of service to patients and the ability of staff to make the best use of their skills, resulting from inadequate consultation with medical and nursing staff during the design stages. The point was made many times to us that the eventual users of the health centre should always be involved with its design and planning from the beginning. We certainly endorse this.

2.16 We have no firm views on the merits or otherwise of providing services from purpose-built health centres, group practice premises or even adapted or improvised premises but we have few doubts that it is important that the premises from which the team work should be well-designed and of sufficient size to provide adequate accommodation for the members of the team and their activities. We therefore welcome the emphasis given in the DHSS Health Circular HC(79)8 "Primary Health Care: Health Centres and other premises"³⁰ to the importance of involving the eventual users of the premises in the Project Team. The Department has also issued an Interim Print of a Building Note on Health Centres³¹; while we consider that improvisation and adaptation have on occasions served very well and that "design-guide" quality premises are by no means always necessary, this provides a sound basis for future development. We also note that the Schedule of Fees and Allowances for General Medical Practitioners in England and Wales³² makes it clear that accommodation for attached staff, including treatment room facilities, falls within the conditions of both the cost rent and improvement grant schemes, and we hope that more GPs will avail themselves of the considerable financial assistance that can be provided under these schemes.

2.17 WE RECOMMEND THAT

- i. as advised in Health Circular HC(79)8 the eventual users of primary health care premises should be consulted during the initial design stages of new premises and be represented on the Project Team;
- ii. all new or adapted practice premises should be of sufficient size to accommodate the members of the team and their anticipated activities;
- iii. new or adapted premises should be designed wherever possible to facilitate informal contact between team members; and
- iv. any revision of the Building Note on Health Centres should take account of our comments above in respect of the size and design of the facilities that should be provided and it should so far as possible be sufficiently broadly based to provide guidance on the design of group practice premises.

Manpower deployment

2.18 Deployment of available manpower is also crucial for the effective working of teams, particularly at times when recruitment of new staff is constrained by pressure on resources. Over the past decade there has been a slow but steady growth in the number of GPs; there is no doubt that this has in part been due to the changes which have occurred in general practice over this period and there are encouraging signs that a career in general practice has become more attractive to new medical graduates now that general practice is being taught to under-graduates. Deployment of GP manpower, so far as it is amenable to control, is largely the responsibility of the Medical Practice Committee (MPC). It was put to us that there was a need for greater flexibility in GP deployment, particularly in inner city areas, to take account of the quality and type of service being provided by existing GPs in a particular area. We were told about some areas in which a high proportion of GPs are incapable or unwilling to provide a proper level of primary care. But, because the nominal ratio of GPs to population was

higher than average, the establishment of additional practices was prevented by the MPC despite considerable evidence of an inadequate level of services in the area. (This point is discussed further in Chapter 5.) In this connection we regard the recent report of the joint DHSS/GMSC* Working Party on Under-doctored Areas³ as a useful starting point, and welcome the proposed introduction of an improved initial practice allowance in practice areas considered to have inadequate GP services. However we also consider that further study of possible incentives to attract GPs into such areas would be valuable.

2.19 Two aspects of deployment of nursing staff were mentioned to us; the first was in relation to the need for a 24-hour, 7 days a week nursing service in the community to provide a basic "out of hours" service on the same lines as that provided by GPs. Some health authorities already provide a night nursing service and weekend cover, but for others there may be considerable resource problems if such a service needs to be newly introduced. We consider that the aim must be for every health authority to provide adequate basic night and weekend nursing services, although we recognise that this may take some time to achieve everywhere.

2.20 The second aspect of staff deployment which was mentioned to us was in relation to the balance of registered and enrolled nurses and auxiliaries within the team. The range of duties undertaken by nurses working in the community is considerable, extending from those within the competence of a nursing auxiliary working under supervision to those duties which invariably require execution by a registered nurse with district nurse training who is responsible for the assessment of the patient's need for comprehensive nursing care, and including the use of management skills to co-ordinate services and foster liaison with nursing and non-nursing colleagues. Similarly, there are some tasks within the health visitor's remit which can be delegated to less qualified staff, so long as such activities are monitored by health visitors. The need to make proper use of the skills and experience of staff trained to varying levels of competence is one which we consider important, but it is often difficult to achieve. There is a need for patient-dependency studies to be carried out, using more scientific methods. Such studies should be carried out for staff working both in the clinical and preventive fields. We found little research material to assist us in our deliberations in relation to patient-dependency and the district nursing service, and even less in relation to the client groups cared for by health visitors. Clearly such research will take some time to accomplish, and in the meantime we consider that all Nursing Officers responsible for community services should carry out continuing appraisals of staffing requirements according to local needs. We also recognise that staff allocation and deployment levels will need to be sufficiently flexible to accommodate changes in dependency levels produced by developments in medical and nursing care, eg increased numbers of patients with catheters or cardiac pacemakers being cared for in the community.

2.21 It was also claimed that proper deployment of nursing staff was considerably hindered because some Family Practitioner Committees (FPCs) refused to provide information about the size of practice populations for which individual teams were providing services. We agree that information about the size, composition and health needs of the population served by the team is necessary, albeit on a strictly restricted and confidential basis,

*

General Medical Services Committee of the British Medical Association

for the effective planning and management of nursing services in the community. At the same time, effective use of the available nurse manpower also depends on there being sufficient clerical support available to relieve nurses and health visitors of unavoidable clerical tasks which form no part of the clinical or preventive nursing role. We share the view of the Briggs Committee on Nursing that:

"full clerical and other support should be available to community nurses and midwives within the group practice or other centre from which they work".³⁴

2.22 WE RECOMMEND THAT

- i. health authorities should, as soon as possible, make arrangements to provide night and weekend nursing services where these do not already operate;
- ii. research should be conducted into levels of patient-dependency on nursing services in the community in relation to the various levels of nursing skills and experience available in primary health care teams;
- iii. until the results of such studies are available, senior nurses should conduct continuing appraisals of the mixture of trained and support staff within nursing teams in the community;
- iv. in order to facilitate the planning and management of nursing services in the community, FPCs should make available relevant data about practice size, number of persons on lists living outside the health authority boundary etc, to the appropriate nurse administrator on a strictly restricted and confidential basis; and
- v. adequate clerical support should be provided for district nurses, health visitors and midwives.

Patients' Records

2.23 Another vital instrument in the work of the team is the patient recording system. Two major problems regarding the availability and operation of clinical and practice record systems were mentioned to us. The first concerned the confidentiality of clinical records. All health service professionals, and indeed all NHS employees, including staff employed by GPs, have a responsibility to maintain the confidentiality of patients' records. Many team members, conscious of the importance of maintaining confidentiality as the foundation of a good relationship with the patient, are unwilling to allow their colleagues access to their clinical records. This may mean that relevant data is unavailable to other professional members of the team.

2.24 Most of those who raised the question of access to records either reported that all members of the team had access to a centrally compiled clinical recording system - with no perceptible reduction in trust between patient and team member - or advocated free access as a necessary condition for effective team working. The confidentiality of such records is protected by the ethical codes and/or terms of employment of people working in the NHS.

It is hard to see how a primary health care team can function effectively unless all team members have access to patients' records. There is also a need to ensure adequate access, when appropriate, to the hospital records of patients being cared for by the primary health care team. There may be circumstances in which the doctor, nurse, health visitor or midwife would wish to retain confidential notes which would not automatically be available to other members of the team, but in general we consider that all team members should have access to records kept by individual members.

2.25 The other important aspect of patient-recording systems to attract comment was the need for the team to assemble and make use of a practice register as a means of organising the basic data available in patients' records. One example is the age-sex register which can allow rapid identification of groups of patients who are particularly likely to require health care.

2.26 WE RECOMMEND THAT

- i. all team members should generally have access to records kept by other members of the team; and
- ii. each team should review its need for particular types of practice register, and where necessary co-operate to assemble and organise, on a confidential basis within the team, data identifying patients in the practice who are in groups requiring special health surveillance. There may be considerable resource implications - since adequate space and clerical staff will be required - and we suggest that GP members of teams take advantage of existing arrangements by which clerical staff costs can be partially reimbursed by the FPC and costs of any necessary equipment offset against income tax.

Financial management

2.27 A number of comments criticised the way in which the financial structure of the NHS reacts upon the effectiveness of the team. Much of this concerns the relationship between the FPC and the AHA, in that funds for services provided directly by general practitioners are distributed by the FPC, while services provided by AHA-employed staff, particularly in relation to health visiting, district nursing and midwifery services, are funded by the AHA. This has raised particular problems in relation to the reimbursement to GPs of expenses related to AHA-employed staff working in practice premises owned or rented by the GP. The Department's advice to AHAs on what proportion of these expenses should be repaid to the GP by the health authority, incorporated in HN(77) 15435, has been criticised as unfair, unrealistic and ambiguous, and as a serious disincentive to the formation and continuation of primary health care teams. We believe that there is a general lack of clarity in this most complex area.

2.28 The problem seems to have arisen because GP gross remuneration contains an element to cover practice expenses, apart from those directly reimbursed to individual GPs (eg rent and rates, dispensing costs etc) which is based on the national average level of all GPs' expenses whether

working in a team, in partnership without attached staff, or single handed. We were told by the Department that this means that if health authorities were to reimburse GPs for all identifiable practice expenses attributable to attached nursing staff there would be an element of double payment, unless a compensating adjustment were made to the arrangements for indirect reimbursement of practice expenses via the GP's gross remuneration. Such an adjustment is already made in respect of expenses reimbursed by the AHA related to community health service work, unconnected with that of the GP, carried out by attached nursing staff on the practice premises. The Department suggested that extending such arrangements to cover the much wider field of all primary health care work might cause practical difficulties for health authorities in assessing what element of a GP's practice expenses could be attributable to the presence of attached staff. Health authorities would also need to satisfy themselves that such expenses had been necessarily incurred. It was uncertain whether arrangements acceptable to GPs and health authorities could be devised. The Health Departments had offered to assist in individual cases of difficulty between health authorities and GPs and had done so on a number of occasions. The Health Departments also argued that the presence of attached staff could increase the practice's capacity to deal with more patients or to give more services to existing patients, some of which (eg family planning services, maternity services) attracted extra fees. There was therefore the prospect of additional GP remuneration to offset against extra practice expenditure. There were also non-financial benefits to the practice.

2.29 We do not accept the Department's argument. We received no evidence that the attachment of nursing staff to a GP practice decreases the GP's involvement and continuing responsibility; on the contrary there are studies³⁶ which show that GP workload may actually increase. The reason for this is that health visitors and district nurses may identify people requiring medical help at an earlier stage who would otherwise ultimately be admitted direct to hospital without having recourse to their GP. The primary motivation for the full team approach by GPs is the desire to devote as much time as possible to clinical treatment of the patient, whilst increasing patient care and support by those best qualified and trained to do so. Therefore the most important effect of the attachment of nursing staff is the improvement in the quality of care provided to patients by the primary health care team. Whether or not more patients would like to be on a particular GP's list because he is the member of a primary health care team therefore becomes irrelevant, because the GP would be unable to increase his list further without reducing the quality of care he provides.

2.30 Apart from the possible disincentive to GPs considering whether to make accommodation available for attached nurses, we have also had evidence about problems arising from this method of reimbursing expenses including:

- i. complaints from attached nurses about being denied access to telephones and equipment because the GP was not receiving direct reimbursement;
- ii. concern from GPs about unnecessary and/or excessive use of telephones, heating and lighting by AHA-employed staff which made considerable inroads into the GP's remuneration and were difficult to control without acrimony; and

iii. difficulties arising because of the fact that of the equipment required by staff in the team, some will have been paid for by the GP and some by the health authority. It is impractical, and detrimental to the morale of the team, for accounting procedures to be used to determine who is responsible for maintenance, repair and replacement of individual items of equipment.

2.31 WE RECOMMEND THAT

the DHSS should negotiate a national agreement with the GMSC by which expenses attributable to AHA-employed nurses working in premises owned or rented by the GP can be reimbursed to the GP by the health authority.

We recognise that there may be administrative difficulties involved in identifying the precise amount to be reimbursed to GPs, and that some small adjustment to the way in which the practice expenses element in GP gross remuneration is derived may be necessary, but these are minor points compared to the clear need to rectify the injustice of the present system, and to remove the significant element of disincentive to the formation of primary health care teams which it constitutes. We understand that some health authorities have already introduced arrangements on a local basis along the lines we propose.

2.32 Finally a number of other needs were expressed in relation to the support services which should be available to the team, including:

- i. technical and diagnostic services including open access to hospital X-ray departments and pathological laboratories;
- ii. access to Central Sterile Supply Department (CSSD) services;
- iii. access to centralised hospital laundry services;
- iv. more comprehensive liaison with social work services, chiropodists, psychologists, physiotherapists etc; and
- v. effective communications systems (further discussed in 4.29 - 4.31).

2.33 Our experience of the NHS suggests that all these services are available to some teams, but that availability and liaison are variable. In many cases there is no standard national policy in this field other than support for the principle of "open access" to laboratory and other hospital services, even to the extent that no common policy exists for the transport of specimens from GP surgeries to hospital laboratories. In most cases this is seen as an area for purely local determination, but there may be some merit in further investigation of the role and availability of support services for primary health care teams, aimed at assessing the value of and the best way of providing these services.

CHAPTER 3 - THE FORMATION AND MAINTENANCE OF THE PRIMARY HEALTH CARE TEAM

3.1 We received comments about the effects of personality factors on the team, the need for greater clarity and respect for other team members' role, the effects of conflicts between team members both on the personal and the professional level, the need for education and training, and the need for preparation for prospective team members and careful choice of new members when initially recruited.

3.2 Integration of the different disciplines is clearly important in primary health care teams and difficulties may be encountered when practitioners - GPs, health visitors and district nurses - who have been used to working independently and in isolation - are brought together in teams to provide co-ordinated care. We consider that there are four basic prerequisites for the satisfactory integration of the team:

a common objective for the team, accepted and understood by all team members;

a clear understanding by each team member of his/her own role, function and responsibilities;

a clear understanding by each member of the role, function, skills and responsibilities of the other team members; and

mutual respect for the role and skills of each team member, allied to a flexible approach.

These prerequisites may seem obvious, but they are by no means universally recognised and will depend of course on there being a degree of continuity of membership within the team itself.

3.3 We also believe it important to make clear that a fundamental requirement is that the team should have sufficient flexibility to enable all its members to exploit their professional skills to the full, within the unavoidable limits imposed by factors such as resource constraints, the training and experience of individual team members, and above all each member's overall responsibility to the patient.

3.4 If the objectives of the team are well defined, if each member has a clear perception of and values his or her own role and that of his or her colleagues, and if all are aware of the potential pitfalls as well as the advantages of working together as a team, personality conflicts are less likely. A number of ways in which teams could acquire such a well-defined corporate identity were proposed, including:

- i. proper preparation before the team is set up. All prospective team members should be fully involved in the preparation, and the participation of senior nurses to whom the nurse members of the team are accountable will also be important;

- ii. the need for existing teams to examine their own internal relationships and functions, by way of formal and informal meetings, in order to arrive at an agreed view of the overall objectives of the team and increase members' awareness of their own and each other's roles and responsibilities;
- iii. the need for more multidisciplinary training, and training in the specific communication and inter-personal skills required for working in a team, to be included in nurses' and doctors' professional training.

We endorse the need for proper preparation, and think that the second suggestion has considerable merit, although whether it is appropriate will depend on particular circumstances.

3.5 In relation to the third suggestion, which is of more general importance, we are encouraged by the growth of interest amongst educational institutions and training bodies both in education for teamwork, particularly in relation to management, and in training activities conducted on an inter-professional or multidisciplinary basis, some of which are listed in Annex 3. The majority of those giving evidence stressed the role of education in influencing attitudes to teamwork in primary health care, and urged the inclusion of multidisciplinary education in post-graduate courses. We support this. At the same time we consider that it is important for under-graduate medical and basic nursing education to include an element of preparatory training for team working although we appreciate that it may not always be possible for this to be provided in a multidisciplinary setting.

3.6 Those with experience of organising post-graduate education reported considerable logistical difficulties arising from the different lengths and levels of training, as well as problems caused by different teaching methods, and students' expectations. Their experience suggested that the effectiveness of learning was increased by case studies and role playing and we commend these methods. A further problem is student motivation when the multidisciplinary element of training is not an examined component.

3.7 The team itself, whether working from a health centre or from group practice premises, can provide an important focus for training at all levels, and particularly in relation to staff who have hitherto worked in isolation in an area in which the team concept is starting to be developed. They may derive considerable benefit from brief secondments, or visits, to well-established teams before they themselves become part of a newly-formed team.

3.8 WE RECOMMEND THAT

- i. multidisciplinary education in primary health care should be included in post-graduate and post-basic courses, as part of their examined component;
- ii. preparatory training for team work should be included in under-graduate medical and basic nursing education; and

iii. the value of experienced primary health care teams in providing a potential focus for widening practical experience of, and training in, team work at all levels should be more widely recognised.

3.9 Such steps should contribute to a general improvement in the mutual understanding of the roles of different members of the team. We acknowledge, however, that even if roles are clearer and better understood by the different team members, personality conflicts can arise. Two suggestions were made of measures to help with the problem of personality conflicts which arise when two members of the team - even members of the same professional group within the team - are unable to work together for reasons of personality and character, to the extent that the effectiveness of the team as a whole is threatened. The first involved greater flexibility of team membership, with a trial period of six months or a year during which time any request for movement to another team by or in respect of a new member should be responded to immediately and without question. There are a number of difficulties attached to such a suggestion, including potential complications vis-a-vis employment protection legislation, the GP's contractual relationship with the FPC and domestic restrictions on mobility for many NHS staff. We consider, therefore, that this suggestion cannot be put forward for general adoption although where individual circumstances permit it should be considered. In the majority of cases the solution will lie in making renewed attempts to bring about improved relationships within the team, coupled perhaps with more sensitive selection procedures for new members.

3.10 The second suggestion was that whenever an established team takes on a new member the team should be represented on any selection or appointments committee. Again there are a number of practical difficulties involved with this, but we consider that, wherever practicable, potential new members of teams should have the opportunity to visit and talk informally with the rest of the team, before they are formally appointed to it.

3.11 Particular difficulties were reported to us in relation to the increasing numbers of nurses directly employed by GP practices. A number of GPs commented that these staff provide an invaluable service by assisting in the surgery and in the treatment room and by carrying out treatment room tasks such as giving injections, taking blood and other samples for laboratory tests, renewing dressings etc. We agree that such duties are appropriate for qualified nurses to carry out under the general supervision of the GP, but there are a number of areas of concern;

- i. we have heard reports of increasing involvement amongst practice nurses in what have hitherto been district nursing tasks, including making first contact visits to patients in their own homes, although few will have had the benefit of district nurse training;
- ii. many practice nurses are isolated from the nursing profession as a whole, being outside the professional nursing structure in the NHS. They may thus be deprived of advice and support from members of their own profession, and, in many cases, of the opportunities for further education and training provided under the auspices of the various professional nursing organisations. They will also be unable to call on AHA - supplied facilities, including nursing aids and equipment;

- iii. the legal position is complex, particularly in relation to the extent of the GP's vicarious liability for the practice nurse's actions.

3.12 There has apparently been a considerable increase in the number of practice nurses employed in recent years; precise figures are not available, but information from research studies such as those carried out by Dr B L E C Reedy³⁷ and Dr Anne Cartwright³⁸ suggests that there may already be well over 3000 (most employed on a part-time basis) - and this is a matter of some concern to us. This increase may in part be ascribed to the inability of health authorities to provide primary health care nursing services to the scale required. The 30% of the cost of employing practice nurses not reimbursed to the GP is still a considerable financial disincentive to their employment if adequate alternatives were available. On the other hand we are aware that in many cases GPs prefer to employ their own staff. We also recognise that in some cases this is because of the unwillingness or inability of health authority employed nursing staff to work in the treatment room at the GP's surgery. We consider that the nursing team within the primary health care team should always be involved in the whole range of primary health care services provided by the team, including treatment room work, although we recognise that such work is not invariably appropriate for the district nurse herself to undertake. We would therefore view with concern any tendency towards a division of nursing duties within the team which would limit the district nurse to nursing duties in the home, while work at the surgery is regarded as the province of practice nurses. Any constraints placed on health authority employed nursing staff which might tend to encourage such a development should therefore be reviewed.

3.13 At present, nurses directly employed by GPs have a definite role to play in the delivery of primary health care, but their role and relationship with the health visiting and district nursing services need to be closely examined. We believe there is also a need to ensure that training facilities are available to enable practice nurses to carry out their expanding duties effectively and to keep in touch with professional developments. Such arrangements will have to be discussed by the Department, the General Medical Services Committee and nursing organisations. In addition if there is to be, as we suggest, increased involvements of members of the district nursing team in treatment room work, there may also be a need for additional training to be provided, particularly in relation to knowledge, skills, techniques or procedures not included in basic nursing education and training.

3.14 WE RECOMMEND THAT

- i. the Department, the GMSC and nursing organisations should consider the role of the practice nurse, her relationship with health authority employed nurses, and her need for training;
- ii. in the longer term, health authorities should make sufficient resources available to enable these nurses to be employed within the normal NHS structure in a fully integrated nursing service without prejudice to existing arrangements where these are working satisfactorily; and

- iii. constraints which place limits on a range of duties which health authority employed nurses may undertake should be subject to periodic review by health authorities in consultation with local medical committees (IMCs), along with any other factors which might prevent attached nursing staff working alongside GPs in surgery-based treatment rooms.

3.15 Our attention was also drawn to the need for improved training for receptionists and secretaries, and we particularly welcome the initiatives which have already been taken to improve the training available for these staff. The Association of Medical Secretaries (AMS) has pioneered training courses leading to the Diploma and Certificate of Medical Reception at a number of Colleges of Further and Higher Education. The 1977 report of the Working Party on Training for Receptionists in General Practice 39 recommended that the Department should produce a handbook for receptionists, and it is hoped to issue this during 1981. Despite this, as the AMS themselves acknowledged in their evidence to us, much remains to be done - only 2500 receptionists out of a total of some 25,000 have undertaken the AMS courses over the last 14 years and although health authorities do provide some training this is mainly based on hospital needs. We note that the Royal Commission recommended 40 that FPCs should meet the full cost of attendance of GPs' receptionists at training courses.

3.16 The scheme of direct payments for ancillary staff already provides for the reimbursement to the GP of 70% of the costs of such training and the remaining 30% is counted as a practice expense. The profession itself, via the GMSC, has expressed its preference that this should continue to be the case. We would not call for changes in the way this training is funded, but we do consider that Regional and Area Training Officers in association with their nursing colleagues should make greater efforts to encourage receptionists and secretaries to undertake training, and to publicise amongst GPs the existing arrangements for reimbursement of the costs involved.

3.17 WE RECOMMEND THAT

greater efforts should be made to encourage receptionists and secretaries to undergo training specifically orientated towards work in primary health care and the existing arrangements for reimbursing the costs associated with such training to GPs should receive wider publicity.

3.18 In the larger primary health care teams, there are a number of administrative and managerial tasks not involving any clinical duties or skills which could conveniently be carried out by a lay administrative co-ordinator, or practice manager. These might include management responsibility for non-clinical staff employed by the health authority, oversight of the maintenance of the practice premises and equipment used by the team, and a number of general co-ordinating and liaison functions. There would be considerable resource implications if every team included a practice manager, even on a part-time basis, and it would be inappropriate for us to recommend that all teams should include such additional administrative support as a matter of routine; whether or not any particular team includes a practice manager should be decided at local operational level.

CHAPTER 4 - MANAGEMENT AND ORGANISATIONAL FACTORS

4.1 Many of the management problems brought to our attention were really concerned with the basic difference of orientation between nurse and doctor arising from the two professions' different background, training etc. In practical terms this can only be surmounted if those concerned are aware of its potential for causing difficulties, and try to take this into account in their work and in their relationships with members of other professions. The comments we received indicate that it is more often the GP who finds it difficult to come to terms with this. He consequently may blame the nurse management structure and the attitudes of senior nurses for problems which may be rooted in his own unwillingness to communicate with and consult his nursing colleagues in the team, or his unwillingness to understand the different circumstances and constraints under which they operate. Furthermore, the GP, as an independent contractor, may understandably have a protective attitude towards his own independence and self-sufficiency, which leads him to be suspicious of nurse management. We can see no immediately obvious solution to the problem other than to urge its resolution through closer contact and the determination to reach better understanding.

4.2 Nevertheless a number of the comments made to us suggested that improvements in the effectiveness of management and closer examination of the organisation of services in relation to particular circumstances might help to increase the effectiveness of teams.

4.3 We expected many of the management problems raised in evidence to us to be related directly to the reorganised structure of the NHS, but in fact few of the major problems were directly associated with the changes made in 1974. Clearly the major criticisms which have been made elsewhere of the post-1974 structure - of decisions being referred to higher levels, of the length of time involved in effective decision-making, and of the inordinate amount of consultation needed before decisions are taken - affect primary health care just as they affect other parts of the NHS, but these particular points were raised infrequently in relation to the primary health care team.

4.4 The only major point made in relation to the management structure of the NHS since 1974 was that the attempt to integrate the three aspects of the pre-re-organisation health service - hospital services, family practitioner services, and local authority health services - had not entirely succeeded, and the continuing administrative isolation of family practitioner service tended to react unfavourably against the effectiveness of teams. This underlines a frequent call in the evidence we received and clearly also in that submitted to the Royal Commission for the abolition of FPCs and for FPCs' functions to be absorbed by the health authority. We return to this in paragraph 4.11.

Nurse Management

4.5 It is thus the separation of the structures of general practitioner services and the remainder of the NHS - independent contractors linked to virtually independent FPCs contrasted with staff working within a hierarchical management structure - that is the basic cause of the difficulties rather than the particular structure introduced in 1974.

4.6 It is salutary to consider the potential complexities of the management and contractual structures within which the relatively few members of any particular primary health care team find themselves. In this respect the general practice structure is considerably more simple; the GP is independent of direct management control as he provides services under a contract with the FPC and influences the working of the latter via the LMC. Apart from his contractual obligations, and questions of professional conduct monitored by the General Medical Council, he has few constraints. In contrast the Health authority employed nursing members of the team are responsible directly to their senior officers, and ultimately to the health authority, and the health visitor and district nurse have management responsibility for other nursing staff - SRNs, SENs, students and learners, and nursing auxiliaries - in the team. The GP himself may have assistants, trainees or students, and practice nurses, in addition to receptionists, for whom he will be responsible.

4.7 A number of comments were critical of the relationship between the primary health care teams and senior nurses responsible for the overall management of health visitors and district nurses. Some of these indicate that many GPs do not appreciate the difficulties involved in organising nursing services or in the allocation of scarce resources, probably because they themselves have no experience of such management responsibilities. But others, mainly from GPs but also from nurses, expressed concern about the impact of management decisions on the effectiveness of the primary health care team. For example, it was said that:

- i. senior nurses were, on occasion, redeploying nursing staff and in some cases had terminated attachments without consulting beforehand the GPs and nurses involved;
- ii. nursing staff were being redeployed on a temporary basis to provide cover for colleagues away sick, on holiday or on training courses, at very short notice so that other members of the team had insufficient time to rearrange their working schedules to take account of their colleague's absence; and
- iii. there were sometimes difficulties arising out of conflict between health authority policy and the GP's expectation of what a nurse should do; eg in the fields of vaccination and immunisation, and of family planning.

It is not always obvious to GPs that what they regard as failings in nurse management generally arise from pressure generated by conflicts between the needs of the team and the responsibility of the health authority to provide total services over a wider area. In most cases the basic causes are failures of communication and unfamiliarity with management arrangements.

4.8 WE RECOMMEND THAT

whenever changes in deployment of nurses are impending, the appropriate senior nurse should always ensure that all who are substantially concerned with the working of the team are adequately informed.

Wider Management Issues

4.9 Some of those who raised problems relating to the management of nursing staff attributed them to the effects of the 1974 reorganisation, but the introduction of nurse management predates this. It is probably true to say that the changes and uncertainties resulting from the 1974 events have not

helped, although many of these problems are similar to those described in the Report of the⁴¹ Working Party on Management Structure in the Local Authority Nursing Services in 1969. Certainly many senior nurses in newly-created posts, sometimes lacking in community nursing experience, and with wide-ranging responsibilities and under considerable pressure, may not have felt able to devote sufficient time and trouble to the initiation of effective liaison links with individual GPs.

4.10 A wide variety of solutions (some involving fundamental reforms) were proposed to us, including:

- i. all health visitors, midwives and district nurses should be employed by FPCs;
- ii. health visitors, midwives and district nurses should cease to be employees and instead become independent contractors on the same basis as GPs;
- iii. GPs should cease to be independent contractors and instead become salaried employees of the health authority with their own management structure;
- iv. FPCs should be dismantled and their functions absorbed by the health authority;
- v. formal primary health care liaison committees should be created= at District level, reporting to the District Management Team, taking responsibility for all operational matters relating to the development and working of primary health care teams;
- vi. informal liaison links should be increased, and initiated by senior nurses where not already existing;
- vii. all senior nurses responsible for health visiting and/or district nursing services should have had significant recent experience of nursing in the community.

4.11 Some of these suggestions are clearly not practical; there is no evidence that a majority, or even a significant minority, of GPs or nurses would wish to change their status or the basis of their employment to the extent required for the implementation of any of the first three suggestions. They are in any case far more radical than the problems themselves require. The fourth suggestion - that FPCs be dismantled and their functions absorbed by health authorities - is more relevant and we have already mentioned that we received many comments that the integration of primary health care within the NHS is inhibited by the separate FPC structure. We note the Royal Commission's finding that in Scotland the system whereby the duties of the FPC are divided between LMCs and the administrative function of the NHS works without apparent detriment to GPs or to the NHS as a whole.⁴² We have some sympathy with that viewpoint but have subsequently learned that Ministers do not intend to make any dramatic changes in the administration of Family Practitioner Services although they will be looking for clearer links between the new district health authorities and FPCs in the planning of services.⁴³

4.12 The suggestion to establish formal primary health care liaison committees, although attractive at first sight, does not comment itself to us. Indeed it would be likely to do more harm than good. Not only could the creation of a formal committee lead to a degree of inflexibility not present with informal arrangements, leading to delays in reaching decisions and solutions to management problems, but unless such a committee were to be provided with the power to enforce its decisions and recommendations, which would cut across the principle of consensus management, it would be unlikely to motivate GPs to any degree of active participation. Finally the creation of such a committee would further complicate and duplicate elements of the already convoluted advisory system within the NHS.

4.13 However, we have no doubts that the effectiveness of teams generally would improve if there were better communication at the operational management level and we would therefore strongly endorse the final two suggestions. Many GPs and senior nurses have commented to us about the positive gains in management terms achieved by the creation of informal links, whether initiated by nurses or GPs. As it stands the obligation is placed solely on senior nurses. We feel sure that many do this already but we believe that more could still be done by them to produce the kind of team relationship that is so essential to effective team operation. But recognition that the senior nurse should in general take the lead on this should not preclude GPs from taking the initiative themselves; for example, LMCs may wish to invite the appropriate senior nurse to attend their meetings on relevant occasions. We understand that this already happens in some cases.

4.14 We also consider it most important that all senior nurses closely involved with primary health care should have had considerable experience in the primary health care field, because there is little doubt that some of the decisions taken by senior nurses lacking in experience of community nursing can make for difficulties in the establishment and operation of primary health care teams. It is essential that they should be in tune not only with their staff but also with the legitimate needs of the GPs with whom their staff work. We also consider that more opportunities for joint formal and informal training in management should be provided for both senior nurses and GPs.

4.15 We are concerned about the proposals in "Patients First" to devolve management responsibility to the lowest possible level, and particularly to locate unit management teams - administrator and nurse in conjunction with medical staff - at:

"each major hospital, or group of hospitals, and associated community services".⁴⁴

In many cases the catchment area of the major hospital may not be the most effective management unit for community services, and any implication that hospital considerations will be paramount in determining management arrangements would result in management at senior nursing levels being even less sensitive to or experienced in aspects of primary health care. It would also mean that the predominance of the "hospital voice" in the priorities debate already referred to in paragraph 2.8 will be further intensified. Furthermore it is the Government's stated intention at one and the same time both to reduce management costs and to strengthen hospital management. It is clear therefore that the main impact of a reduction in management resources could fall on the community services, and the impact would be especially hard

on the major contribution to patient care which health visitors, district nurses and midwives make along with their general practitioner colleagues. On a more general note, we are also concerned that the general confusion likely to accompany such a major restructuring programme may make it even more difficult to identify and rectify management problems adversely affecting the performance of primary health care teams.

4.16 WE RECOMMEND THAT

- i. senior nurses, GPs, attached nurses and health visitors should take advantage of all opportunities to strengthen and improve informal liaison and communication links;
- ii. health authorities should only select nurses with considerable experience in the primary health care field for appointment to nurse management posts closely involved with primary health care;
- iii. more opportunities should be provided for joint management training for GPs and senior nurses with primary health care responsibilities; and
- iv. the Government and health authorities should seek to ensure that the proposed changes in the management structure of the NHS strengthen the effectiveness of the management of primary care services by taking account of the fact that management considerations in the community are often different from those relevant to hospital management. It should also recognise and avert the risk of strengthening hospital management at the expense of reducing the effectiveness of the management of health services in the community.

Management within the Team

4.17 In a small group effective management is primarily a matter of effective communication and clarity about the role and objectives both of the team and of its individual members. We were told many times that maximum flexibility in the internal structure of the team was essential to ensure that roles and functions could change as team members developed and increased their skills and integration with other members of the team. This seems right, and indeed essential in order to accommodate changes in team personnel. We have drawn attention to some of the problem areas, and suggested ways of ameliorating them, in Chapter 3.

4.18 A number of specific points were made to us in relation to the internal management of the team. Many of these were concerned with the difficult question of leadership and relative status of team members. Several comments we received argued that the team should function from a basis of complete equality; others wanted to exclude secretaries and receptionists from full membership of the team. Some claimed that the GP must be the leader of the team because he has "ultimate responsibility"; others specifically opposed such a view on the basis that nurses not formally employed by the GP are responsible for the way they carry out their jobs to themselves and to their nurse managers and not usually to the doctor "in charge" of the case. There was also considerable concern amongst a number of GPs who thought that they were clinically responsible for all treatment provided by nurses attached to their practice, although they had no managerial control over those employed by the health authority.

Legal Liability and Leadership

4.19 This latter point raises an area characterised by considerable confusion - the extent of the doctor's legal liability for treatment he does not provide directly to the patient. The GP has a contractual responsibility to provide medical services to patients on his list and is professionally responsible for the advice and treatment he provides. As we understand the position, while the GP maintains general clinical responsibility for "his" patients, his legal liability is limited to those actions he performs himself or, vicariously, to those performed by staff over whom he has some measure of control. He will have no direct liability in respect of actions performed by a nurse, if these relate solely to nursing duties for which she has been properly trained, and will have vicarious liability only insofar as the nurse is employed by him, or otherwise can be said to be under his control. In the normal sense of attachment, therefore, in which the senior nurse has management accountability for her staff on behalf of the health authority, the GP would not be liable as a result of the nurse's action unless his own diagnosis or prescription was faulty, or unless he had failed to satisfy himself that the nurse was qualified to carry out the task in question. We recognise that this is a complex matter, and that there are few legal precedents, but the above analysis, taken in conjunction with the helpful advice in paragraph 3 of HC(77)22 - "The extending role of the clinical nurse - legal implications and training requirements"⁴⁵ - should be sufficient to provide guidelines in most circumstances.

4.20 The comments made to us in relation to the question of leadership were mainly in four categories:

- i. teams were less effective because GPs were unable or unwilling to take on the responsibility of leadership;
- ii. teams were less effective because GPs too readily took on the role of leader, as if by right, and without necessarily acknowledging the scope of the work covered by other members of the team, thereby alienating members of the other professions involved;
- iii. leadership of the team in any given situation should be assumed by the professional most closely involved;
- iv. there was no clear need for a leader per se, since the team was made up of professionals of differing skills but equal status, and on matters requiring consideration by the team as a whole co-ordination rather than leadership was necessary.

4.21 It is important to distinguish between clinical responsibility for the patient and leadership. If there is a team leader, he or she will be more often concerned with the general organisation and management of the team and with motivation than with questions related directly to patient care. There is a frequent need for motivation and co-ordination - leadership qualities which are more important than the ability to give orders - but these qualities are not uniquely associated with any one of the professions involved in providing primary health care. In view of this we would recommend that the need for, and identity of, the leader of the primary health care team should be decided by the members of the team concerned in the light of their own assessment of their own and their colleagues' needs and capabilities, and that no attempt should be made to relate leadership automatically to any particular profession. Flexibility and mutual acceptance should be the keynote.

Health Visitors and the Child Health Service

4.22 The changing status of the nursing profession is another aspect which has contributed to the problems. The comments we received suggested that many GPs were unwilling to accept that nurses have any autonomous role, do not understand or appreciate the basis of professionalism and improved training for the nurses' new status, or were concerned when nurses positively asserted their independence. In particular it appears that the increasingly important contribution of the health visitor in providing services to the whole population rather than just to children may not be fully accepted. Some GPs do not understand either the content or the value of the health visitor's role generally, and in particular its preventive rather than curative orientation. In many cases, particularly in relation to health education and child health, the health visitor will be acting independently. Furthermore, in relation to the health visitor's concern with children she may in many cases be working as a member of another team based on **one** or more child health clinics and involving the clinic doctor and other supporting staff, and may also work in schools as part of the school health service.

4.23 The existence of a parallel team in many areas providing some aspects of primary health care services based on the child health clinic may in itself lead to difficulties. If mothers are accustomed to taking their children to clinics for developmental assessment and other continuing advice and treatment, they may well look to the clinic to provide other health services which would ordinarily be provided by the team, or in the event of the GP being called in to treat a child, he may lack knowledge of the child, or relevant information which has been collected for clinic purposes may be unavailable. Many GPs are unable to provide child health services such as developmental assessment. Others may be unwilling or may not see the need to undertake the post-graduate training necessary to enable them to do so. So long as a separate system of child health clinics is necessary to provide these important primary health care functions, it is important that effective liaison be maintained between clinics and primary health care teams. In many cases, the health visitor, with responsibilities embracing both clinics and teams, may be able to provide liaison to the required degree, but sometimes it may be necessary for more formal arrangements to be instituted, possibly involving mutual exchange of patients' records.

4.24 At the same time we consider that child health services could benefit if GPs were in general more closely concerned with their planning and organisation, in the same way that many of those responsible for hospital-based paediatric services are already. As regards the wider field of prevention and health education, we consider that the role of the community physician in providing the co-ordinating focus and overall direction for large scale preventive and health education programmes is important and requires a considerable increase in the amount and effectiveness of liaison between him and those providing primary health care services in the community.

4.25 WE RECOMMEND THAT

- i. health authorities and IMCs should consider whether liaison arrangements between primary health care teams and child health clinics are adequate, and if they are not, should take steps to improve them; and
- ii. community physicians should become more closely involved in primary health care team activity especially in planning preventive and health education programmes.

Midwives

4.26 The changing nature of the midwives' role can lead to difficulties in some circumstances. A very large proportion (98% in 1978) of births now take place in hospital and as a result the number of midwives working exclusively in the community has decreased significantly (from 5,298 in 1965 to 2,984 in 1979) and the role of those remaining has also changed. Over 80% of babies are delivered by midwives and this, coupled with the increasing numbers of early transfers from hospital to the mother's home, means that close liaison between midwives and other members of the team, particularly GPs and health visitors, is essential in providing proper ante-natal and post-natal care. The increase in early transfers has also led to greater emphasis on shared care and "mixed attachment" of midwives to GPs and hospital maternity departments.

4.27 But the attachment of a midwife to a single primary health care team is now rarely practical. In her case therefore the problem of maintaining and co-ordinating her work with that of a number of primary health care teams may be considerable. She will also be managed by a senior midwife who may have pressing management responsibilities in respect of hospital midwifery staff. We would therefore urge senior midwives to review carefully the liaison arrangements already existing between community midwives and teams and to improve them where necessary.

4.28 WE RECOMMEND THAT

the existing arrangements for liaison between community midwives and primary health care teams should be reviewed carefully and senior midwives should take steps to improve them where necessary.

Communications

4.29 We received a great deal of evidence to the effect that the internal integration of the team was vital and that improvements in internal communications were needed. Both formal and informal modes of improving communication were advocated, including:

- i. regular formal meetings of the whole team to discuss the team's internal management, general treatment policy, and particular cases;
- ii. premises designed to facilitate formal and informal contact between team members (discussed in more detail in Chapter 2); and
- iii. the need for team members to ensure so far as possible that their colleagues can easily contact them to discuss problems, make referrals etc.

4.30 While regular meetings are undoubtedly helpful to the integration of teams, any attempt to adhere rigidly to an inflexible formula in this respect would be misguided. On many occasions meetings of the full team to discuss items on a predetermined agenda will be necessary but undue formality should be avoided. Frequent contact between team members is however vital as are effective means of day-to-day communication at the operational level.

4.31 WE RECOMMEND THAT

- i. premises used by primary health care teams should have adequate space for meetings of the full team and be designed to facilitate and encourage informal day-to-day contact between team members;
- ii. all teams should agree procedures to ensure that their colleagues can easily contact them when necessary; and
- iii. improvements in communications systems should be actively pursued wherever they can be cost-effective (eg when GPs already operate a "bleep" or similar system and extending this to include nursing staff would be relatively inexpensive).

Secretaries/Receptionists

4.32 A number of comments stressed the importance of the Secretary/receptionist in facilitating communication within the team. Some of these comments were critical; that receptionists could, and sometimes did, hinder communication by denying access to the GP for patients as well as for other members of the team or by inadequate transmission of oral messages. In relation to this, we were particularly interested in the results of the survey conducted by Dr Ann Cartwright and Robert Anderson of the Institute for Social Studies in Medical Care which found that:

"Among the 86% (of patients) who had any contact with a secretary or receptionist, half, 49%, described them as "very helpful", two fifths, 40%, as "helpful", three per cent as "unhelpful" and one per cent as "very unhelpful". (Seven per cent made other comments). So the stereotype of the dragon protecting the doctor from importunate patients would appear to be a reality for only an unfortunate few. When asked specifically 72% felt the secretaries or receptionists helped them to get to see the doctor, 6% felt they made it difficult and the others did not see their role in these terms".

Furthermore, about 60% of patients said they were never asked by the receptionist why they wanted to see the GP, and only 19% of those who were asked felt the receptionist asked too much about why they wanted to see the doctor.⁴⁶

4.33 However, a number of comments, particularly from nurses, were critical of receptionists' attitudes, and there is a general feeling, often voiced by receptionists and secretaries themselves, that more training is needed to enable them to play their full part in increasing the effectiveness of primary health care teams. One of the comments made to us by the Association of Medical Secretaries was that:

"There appears still to be reluctance to release staff for training and in some cases there seems to be a tendency for doctors to favour the "sitting next to Nellie" approach, with the result that the functions of other sections of the health service are not understood and this valuable liaison and co-operation is lost".

Moreover it should not be overlooked that the receptionist's work can be made more difficult by team members failing to update dairies or appointment registers. Team members need to acknowledge the important role played by the receptionist and she needs to appreciate that she is working in a team and not just for the doctor.

Attachment of Nursing Staff

4.34 The GP, as an independent contractor, has a responsibility to provide medical services to patients he accepts on his practice list, and to any patients otherwise unable to join a GP's list who are allocated to his list by the FPC. In contrast the health authority has a responsibility to provide health visiting, district nursing and midwifery services to all those living within the geographical area served by the health authority, and it employs nurses and midwives to fulfil this responsibility. It is accepted that, within reason, any patient should be able to register with the GP of his or her choice. At the same time the health authority has a responsibility to provide the best possible community health service within the resources available, and this implies ensuring that, again within reason, available resources are deployed in the most effective way. Conflicts can arise as a result which may cause difficulties for the primary health care team.

4.35 Arising from this, a number of problems which affect the attachment of nursing staff to GP practices were mentioned:

- i. that when nurses are attached to GP practices adequate primary health care nursing services are less likely to be provided for people not registered with a GP. Even if, for example, an attached health visitor visiting a house-hold notices a recently arrived family not on her own list, she may well assume that services are being provided by a health visitor attached to a different team working in the area when the family has in fact failed to register with any GP. It was put to us that, where a health visitor is responsible for services within a geographically defined area, this potential confusion is less likely to arise. Furthermore, it is claimed that this latter method of working allows the health visitor or district nurse to build up an intimate knowledge of the social and environmental characteristics of her particular "patch" which attached staff would be unable to do to the same extent. Moreover a health visitor becomes known within a geographical area to residents and is more likely not only to "find" families but also to have families refer themselves to her. Comment was made in this respect about one urban AHA in which it was estimated that 10,000 children in the 0-5 age group out of a total 0-5 population of 70,000 were not receiving visits from health visitors, when the latter were attached to GP's practices;
- ii. that where health visiting and district nursing services are not organised on a geographical basis, there is excessive expenditure in terms of both travelling expenses and nursing time because of the inevitable overlap of GP practice areas;

- iii. that where a significant proportion of GPs are working on a "single-handed" basis from widely separated premises, there are often insufficient numbers of health visitors and district nurses for "one-to-one" attachment to be feasible. This means that one of the fundamental advantages of teamwork - close co-operation between the professionals involved - is necessarily lost;
- iv. that in many cases GP practices extend across health authority boundaries, which means that reciprocal arrangements have to be negotiated between the districts or AHAs involved to enable attached district nurses, health visitors and midwives to provide services outside their "home" territory; and
- v. that in circumstances in which the health visiting, midwifery and/or district nursing staff are based on premises a considerable distance away from the practice premises - eg when the GP's premises are insufficient to provide accommodation for attached nurses and health visitors, or when child health services are provided at clinics some distance from the practice premises - such staff spend a considerable time away from the practice premises.

4.36 Some health authorities faced with these problems, which are particularly acute in inner urban areas, have "solved" them by reverting entirely to a system of geographical allocation of nursing staff. Others have found a variety of compromise solutions in which nurses have a fundamental responsibility for a defined geographical areas, but are "aligned" with particular GP practices so that they take on additional responsibilities for those patients in the practice who live outside "their" patch, liaising with their opposite number in the particular area as necessary. An alternative solution proposed by many nurses and a few GPs, is for the GPs themselves to restrict their practices to particular geographical areas, to eliminate wasteful travelling and create a closer identification with a particular community. In many areas this has happened naturally as a result of geographical features, and we noted that some progress in zoning GP practices has been made in areas which previously have suffered from these problems.

4.37 WE RECOMMEND THAT

Where it is thought that zoning the areas served by group practices might make for easier formation of primary health care teams, LMCs should examine existing arrangements to see whether agreement could be reached by the GPs concerned voluntarily to limit, or zone, areas served by the different group practices and/or partnerships. It is, of course, important to bear in mind any risk of significantly reducing the patient's freedom of choice of GP and we would therefore recommend that LMCs consult with Community Health Councils (CHCs) when considering action on this recommendation.

4.38 We are convinced that teamwork is the most effective way of delivering primary health care to patients, since duplication and overlap of work can be avoided and the skills of individuals used to the full only when the members of the team work together. We would not, however, wish to prescribe any particular method of team working, nor to claim that effective primary health care delivery only occurs where teams exist. There may be some cases where

attempts to develop and maintain teams may be such an uphill **struggle** as to make the expected benefits seem expensive in terms of required effort. In such cases it might be better both from the patient's point of view and from that of the staff to accept a more flexible working arrangement and to allow people to continue to operate as individuals rather than team-members. But we would maintain that there must always be mutual collaboration and understanding.

4.39 We consider that attachment is a very useful adjunct to team working but that it is not essential to the informal style of team which we would see as most likely to be generally attainable. It is important to recognise that the absence of attachment does not necessarily imply that teamwork is impossible - the team approach may be modified, but it should not be abandoned except where it is entirely inappropriate. Other arrangements already exist - some are mentioned in paragraph 4.36 - but the precise arrangement appropriate in any individual case will depend largely on local circumstances. Attachment schemes are unlikely to work where there is a serious shortage of health visiting and district nursing staff, a very rapid turn-over of district nursing and/or health visiting staff, or a large number of single-handed GPs. We have already discussed the very wide range of health visitor and district nurse to population ratios in different parts of the country (in Chapter 2). Where there is a particular shortage of nursing staff, attachment schemes may not be the best means of providing maximum coverage to meet patient need which must be the first priority. In other areas, although we think that attachment schemes can provide an aid both to team-working and to improving effective coverage, we recognise that this will depend on the characteristics of the area concerned - general practice structure and catchment area, geography etc. Accordingly we consider that decisions on attachment can only be sensibly made at the local level.

4.40 However we think it right to emphasise that where circumstances permit, attachment of district nurses and health visitors to GP practices remains the organisational structure most likely to provide a good basis for team work and thus for effective, comprehensive patient care. In view of this we consider that health authorities should undertake a review of primary health care services with particular regard to an assessment of the extent to which the current organisational structure - whether attachment or some other system - is the most likely to promote effective team work in the circumstances prevailing at the time.

4.41 How this review should be carried out will be for local decision, but we consider that any such review should at least involve members of the professions concerned, where possible under a neutral chairman. Possible arrangements range from a joint investigation by a GP and a senior nurse, to a formal committee with terms of reference, regular meetings and formal procedure (although we hope the latter would be unnecessary in most, if not all, cases). This review should seek to ensure, for example, that if attachment arrangements are not appropriate and geographical allocation of nursing duties is preferred, adequate arrangements are made for liaison and communications to facilitate co-operation between the professional staff providing care in the community, and that these arrangements are known to all those concerned.

4.42 At the same time, it must be accepted that personal commitment to the team concept is a major factor in the success of particular teams, and that those responsible for the management and organisation of primary health care services can do much - by persuasion, example and encouragement - to promote the success of the teams with which they are associated. The role of the GP, often the longest serving member of the team and the most readily identified by patients, in promoting arrangements to facilitate co-operation and liaison is vital in this context.

4.43 Finally in this chapter we would again stress the overriding need for the administrative frame-work within which the team is constituted to be flexible and able to adapt easily to changing circumstances. We would, for example, deprecate any attempt to impose a formal administrative structure which would entail the destruction of any successful arrangements for inter-professional co-operation and liaison, however unconventional. Flexibility should extend to the establishment of reciprocal arrangements between health authorities, where practice areas overlap health authority boundaries, so that nurses and health visitors can visit patients living outside their own employing authority's area of responsibility.

4.44 WE RECOMMEND THAT

health authorities in consultation with LMCs should review existing arrangements to ensure that they facilitate team work in the provision of primary health care services. All those involved in such a review should adopt a flexible approach and recognise the need to preserve what already works well in the patient's interest.

CHAPTER 5 - PROBLEMS SPECIFIC TO PARTICULAR GEOGRAPHICAL AREAS

5.1 We were aware at the outset that certain geographical areas, especially inner cities, present particular problems for the development of the primary health care team concept. The "indications" of waning belief in the effectiveness of teams had mainly emanated from declining urban areas, and previous studies of inner cities and of primary care services have already picked out a number of problem areas. We received a considerable amount of comment about the problems of providing primary health care services in such areas; we spoke to doctors and nurses working in Birmingham, Sheffield and London, and written comments we received indicated to us that other declining urban areas had similar problems. We are particularly grateful to Miss Jenny Roberts of the London School of Hygiene and Tropical Medicine, and Dr Brian Jarman, a GP working in Kensington, who provided detailed statistical information and analyses about the primary health care services in Inner London. (We return to the problems of declining urban areas in paragraph 5.5).

Rural Areas

5.2 We also received a certain amount of comment about particular problems associated with primary health care teams working in sparsely populated rural areas. The main problem is the large area covered by practices which involves considerable travelling for nursing staff. This is inevitably costly, but services have to be provided to patients in isolated areas and the financial consequences accepted. On the other hand some of the evidence we have received suggests that teams are more easily formed and work more effectively in rural areas because:

- GPs limit their practices geographically, in order to reduce their own travelling, there is less overlap between practices; and
- some considerable degree of travelling would in any case be inevitable, even if nurses were responsible for a defined geographical area.

However health authority boundaries do not always coincide with GP practice areas, and this can clearly be a particular problem in rural areas in which some practices have a large geographical spread. Flexible and sensible organisational arrangements for nurses, including reciprocal arrangements between the health authorities concerned, should however be possible in such circumstances.

5.3 We consider that, given willingness and flexibility on the part of GPs and health authorities, there is no real reason why primary health care teams should not work effectively in sparsely populated rural areas, although we realise that certain aspects of the service may be restricted as a result of the problems.

5.4 WE RECOMMEND THAT

- i. health authorities should recognise that the problems of sparsely populated rural areas may make the provision of primary health care services more expensive pro rata than the provision of such services in urban areas, but that this additional expense must be accepted as the price of providing a comprehensive service to the community as a whole;
- ii. reciprocal arrangements in relation to the provision of district nursing and health visiting services between health authorities where large GP practices overlap authority boundaries should be negotiated; and
- iii. the possibility of encouraging voluntary zoning of GP practices to reduce the overall amount of travelling necessary should be considered by LMCs in consultation with CHCs.

Declining Urban Areas

5.5 The large number of comments we received about the problems associated with effective team-working in declining urban areas indicates the seriousness with which the difficulties are viewed by those working in the field. We recognise that not all such areas have identical problems. The type and intensity varies from one to another. Inner London is perhaps unique in terms both of the intensity and diversity of its problems, and we welcome the formation by the London Health Planning Consortium of a study group on primary health care. Nevertheless these areas have enough common ground to warrant being considered together. We set out below some of the main problems associated with declining urban areas which affect the workload of, and put pressure on, the primary health care team. We recognise that this is not exhaustive and that not all problems occur in all areas. Two main foci of problems emerged; the patient population and the provision of primary health care itself.

5.6 Analysis of the patient population indicates a generally higher level of need in declining urban areas, primarily resulting from environmental and economic factors such as:

- i. low income - for instance a relevant comment by the Birmingham Inner Area Study ⁴⁷ was that:

"members of the lowest socio-economic groups are 3 times as likely to suffer chronic lasting illness as members of the higher professional groups";
- ii. poor environmental conditions, particularly in relation to housing - most declining urban areas are characterised by high concentrations of either old, decaying houses or badly planned new provision, or both. The former is often associated with higher incidence of respiratory illness, the latter with more psychiatric illness and psychological problems;

- iii. a higher degree of mobility amongst the population, with attendant problems for continuity of care, problems relating to the control of infectious disease particularly in relation to the sexually transmitted diseases, psychological problems, and alcohol and drug related problems;
- iv. a greater proportion of elderly people living alone and in unsuitable accommodation, with considerable implications for health care services in terms of increased morbidity;
- v. a greater proportion of young adults with difficulties in obtaining primary health care either because of their high mobility or because they are homeless or rootless; and
- vi. a higher concentration of members of ethnic minorities, with attendant cultural and language difficulties complicating the diagnosis and treatment of otherwise straightforward illnesses, and reduced effectiveness of conventional health education and preventive programmes.

5.7 There are also problems arising from different attitudes towards and expectations about health care in declining urban areas, particularly in Inner London; eg the traditional use of hospital Accident and Emergency departments instead of primary health care services.

5.8 We received comments specifying many different problems relating to the provision of primary health care services in declining urban areas; many arise directly from the greater pressure on health services generated by the environmental deficiencies already noted, while others outline particular problems relating to the primary health care team. Amongst these problems are:

- i. the limitations of general medical services, characterised by high proportions of elderly, single-handed practitioners, many having been trained outside the UK. Whilst most of these doctors provide an adequate basic service, some do not, and even where an adequate basic service is provided it is difficult to achieve the level of integration between medical and nursing services sufficient for primary health care teams to operate effectively;
- ii. in many cases these GPs have small lists and poor premises, and as a result of the former are unable or unwilling to improve the quality of their premises. Others carry out disproportionately high levels of private practice, and may discourage NHS patients from joining their lists. This contributes to the problem of relatively large numbers of people not being registered with a GP; it also means that other GPs in the area may have higher than average lists;

- iii. there is a relatively greater use of deputising and locum services in general practice in declining urban areas, tending to minimise the opportunities for comprehensive continuity of care making effective liaison with community nursing services particularly difficult. The recent establishment in London of a service which provides out-of-hours general practice cover on a subscription basis to patients registered with GPs under the NHS is a disturbing development;
- iv. if the pattern of general practitioner services is one of a large number of small overlapping practice areas - as it often is in these areas, particularly in London - there are further problems for nursing staff in trying to maintain effective liaison with all the GPs for whose patients they are providing nursing services;
- v. for nursing staff, other major problems include the difficulty of maintaining adequate staffing levels, and of retaining sufficient experienced nurses. A vicious circle operates, particularly in relation to health visitors, in that the quality of the environment leads to disillusionment and the type and pressure of work leads to both difficulties of recruitment and to high turnover; there is then a lack of sufficiently experienced staff to give support to newcomers, which is more serious where the health visitor does not work as a member of a geographically-based health visiting team. Once declining urban areas are characterised by high turnover of staff, training becomes a costly exercise and there may be reluctance to train staff who are unlikely to stay;
- vi. recruitment and retention of all staff is complicated by the unfavourable environment in which they need to live and work, or by high travelling costs for staff living outside the inner areas. Housing costs in particular may cause problems, particularly in relation to the expansion or improvement of GP premises. The comparatively higher living costs and less attractive environment generally conspire to reduce the likelihood of staffing establishments reaching adequate levels and increase the pressure of work for those who are prepared to live and work in these areas;
- vii. the poor quality of the housing stock produces a working environment which both intensifies the difficulties of providing medical and particularly nursing care in the community, and tends to affect adversely the morale of staff working in such conditions;
- viii. a further problem is that because of the deficiencies in the general medical service or of nurse staffing levels, attachment of nursing staff may not be an effective policy, especially in relation to particularly disadvantaged areas in which a relatively high proportion of people are not registered with a GP.

5.9 Clearly the solutions to many of these problems lie outside our particular terms of reference, but generally speaking the problems of declining urban areas and the difficulties associated with providing effective primary health care services in such areas, make it very difficult for the team concept to work properly and, in some cases, have led to the termination of policies of attachment. At the same time, however, the increased need for effective primary health care services arguably makes the primary health care team all the more desirable, and the strongest arguments both for and against the concept of the team have come from those responsible for providing primary health care in these areas.

5.10 A number of different, and in some cases conflicting, solutions were suggested to us, not all of which we consider practical in present circumstances. Amongst the most frequently mentioned were:

- i. a new approach to retirement for elderly Gps especially those working on their own;
- ii. financial incentives for staff working in declining urban areas, not just to cover additional costs of living in such areas but as a positive inducement;
- iii. relaxation of Medical Practice Committee criteria to enable GPs to set up practices in areas in which there is evidence that, although there are numerically sufficient GPs for the resident population, the population is not well-served by the existing GPs;
- iv. better information about ways in which GPs can obtain help in improving their premises coupled with firmer action by FPCs in respect of inspection of premises;
- v. the establishment and expansion of university Departments of General Practice in declining urban areas to provide "centres of excellence", along with a body of general practitioners within the academic sphere to provide a greater degree of mobility, and therefore, the infusion of new ideas;
- vi. salaried appointments to encourage young GPs to practise in these areas, possibly linked to the expanded university Departments of General Practice referred to above in v.;
- vii. improvement of liaison between general medical services and community health services, particularly in relation to information and records;
- viii. the attachment of child health doctors to GPs' practices and **greater** involvement of GPs in child health clinics;

- ix. speculative building of health centres by health authorities to attract new doctors into areas in which a high proportion of existing single-handed GPs or GPs practising from unsatisfactory premises are expected to retire shortly;
- x. the review of nursing attachments schemes for health visitors and district nurses, and where appropriate their supplementation or replacement by geographical working arrangements (see Chapter 4 paragraphs 34 to 33);
- xi. zoning of GP practices where possible to facilitate the work of primary health care teams.

5.11 We note that the recommendations made by the Royal Commission with respect to the provision of primary health care in declining urban areas closely parallel many of the solutions proposed to us for the general improvement of these services to enable teams to function effectively in these areas, and we generally endorse their recommendations about these problems. We recognise that the problems are complex and manifold. A flexible approach is therefore far more necessary than elsewhere, and the measures proposed may take a long time to bring about any significant improvement.

5.12 We also recognise that many of the health problems are the result of more fundamental social, economic and environmental problems which are of sufficient magnitude to warrant a comprehensive approach embracing all these aspects. Until these fundamental problems are solved, measures aimed to improve health services will not be fully effective. Nonetheless there are a number of measures which could be implemented in the short and medium term - apart from action to solve the economic, social and environmental problems - which will go some way towards ameliorating the problems associated with providing primary health care services in these areas.

5.13 WE RECOMMEND THAT*

- i. encouragement should be given to those medical schools in inner cities which have not already done so, to introduce adequately resourced academic Departments of General Practice, and existing University Departments of General Practice in inner cities should strengthen and extend their links with local GPs and primary health care teams;
- ii. the Secretary of State should make use of his powers under Section 10 of the NHS Act 1966 and Section 56 of the NHS Act 1977 to enable health authorities to employ salaried GPs, wherever possible in association with University Departments of General Practice, in declining urban areas where alternative attempts to recruit new GPs prove fruitless;

*Recommendations made in relation to declining urban areas also apply to other deprived areas which for social, ethnic or medical reasons are suffering from the same problems, providing that these other deprived areas can be readily identified and their boundaries clearly defined.

- iii. measures to improve the quality of general medical services provided in declining urban areas should be introduced. These should include arrangements to encourage earlier voluntary retirement of elderly GPs with small lists. Such lists should not be advertised as single practice vacancies but should either be absorbed by neighbouring group practices, which should be allowed to increase the number of partners as necessary, or contribute to the formation of a new group practice. In addition such measures should include investigations of the possibility of those GPs already working in group practices and partnerships voluntarily agreeing to limit, or zone, their practice areas and a review of MPC procedures to encourage the appointment of GPs likely to be favourably disposed towards the idea of teamwork;
- iv. measures to improve the quality of practice premises in declining urban areas, including providing help to GPs to expand or otherwise improve their practice premises to provide a base for a primary health care team, should be pursued and where appropriate given more publicity;
- v. the General Practice Finance Corporation, in exercising its extended powers under Section 17 of the Health Services Act 1980 to buy and lease back practice premises to GPs, should give priority to the improvement of practice premises in declining urban areas;
- vi. where GPs who are in unsatisfactory premises which so not lend themselves to improvement wish to be accommodated in health centres, health authorities in declining urban areas should give priority to their provision;
- vii. where recruitment of **successors** to single-handed GPs working in declining urban areas is going to be difficult unless the opportunity of working in a primary health care team from suitable premises can be offered, health authorities should consider building a health centre in advance of need;
- viii. positive discrimination should be exercised in relation to health visitor and district nurse staffing in declining urban areas, and further fact finding and operational studies should be carried out with a view to establishing how recruitment and continuity of service can best be encouraged;
- ix. to that end the possibility of providing housing at a reasonable rental including the use of accommodation in hospitals no longer required by hospital staff should be pursued; and
- x. health authorities in declining urban areas should concentrate training resources on training more mature nurses, and should provide where appropriate part-time courses for nurses with domestic commitments.

CHAPTER 6 - OVERALL VIEW

After study of much written and oral comment we remain convinced that the concept of the primary health care team is viable and should be promoted wherever possible in the interest of improved patient care.

Attachment and Teamwork

6.1 Our Joint Working Group was set up because there were indications that, although the concept of the primary health care team had appeared to be widely accepted as the method of choice for the delivery of primary health care, doubts were being expressed about its future, and in some parts of the country existing schemes of attachment of district nurses, health visitors and midwives to general practices were reported to be at risk of being dismantled.

6.2 Perhaps this is not altogether surprising in view of the history of the development of the team concept. To begin with, individual attachment schemes developed mainly in areas where general medical services were predominantly delivered by GPs working in groups, and where the composition and the stability of the population favoured the joint deployment of GPs and of nurses employed by local health authorities (LHAs). Early studies indicated that considerable benefits in the form of improved co-ordination of patient care could be derived from this method of organising primary health care services. With the leadership of enthusiastic medical officers of health and their nurse colleagues the establishment of pilot attachments in such localities led relatively easily and quickly to their wider extension and in some instances to arrangements covering entire LHA areas.

6.3 The idea that formal schemes of attachment were the best way to encourage the development of teamwork in primary health care - and thus to improve considerably the quality of care available to the patient by providing a well integrated and co-ordinated pattern of services in the community - spread rapidly. In 1969 the Department formally advised LHAs, in Circular 13/69, to:

"give serious consideration to the desirability of introducing schemes of attachment or association with general practitioners".

Those concerned with the early development of attachment schemes considered that two factors were of vital importance, if attachment arrangements were to produce significant improvements in team work:

- proper preparation of all those taking part; and
- a considerable degree of commitment to the idea of teamwork, and acceptance of the need for compromise, role-flexibility and changing attitudes.

6.4 Some teams widened their membership considerably, to include social workers, dentists, chiropodists and other health professionals, as well as GPs and nurses. In many cases these extended teams worked effectively and provided an admirable service to patients, particularly when the members of the team were accommodated in the same premises, or where proximity permitted ready access to colleagues for consultation and exchange of information.

6.5 In retrospect it is clear that the attachment of nursing staff to general practices was increasingly regarded as the sine qua non of teamwork in primary health care. As a result attachment schemes were to be increasingly set up in areas where the make-up of both general practice and the population was less favourable to their development, and where comprehensive change-over to the new pattern of services presented greater difficulty.

6.6 Many of these less favourable circumstances are described in detail in the main body of our Report - including the pattern of general medical services, the high mobility of the population in some declining urban areas, and personality problems which may not be readily predictable - and in 1974 the reorganisation of the NHS created more problems for the wider development of attachment schemes. There was some hope at this time that general medical services would be more closely integrated into the broader structure of the NHS. On the other hand the radical restructuring of health authorities resulted in greater complexity at the very time when the development of the primary health care team concept was beginning to slow down, as attempts were made to extend it into areas in which circumstances were less favourable to the growth of teams.

6.7 Further problems resulted from the increasing pressure on resources within the NHS during the latter part of the 1970s. Against a background of nurse manpower shortages, especially in socially vulnerable areas, coupled with the less frequent grouping of general practitioners in such areas (which means that a limited number of district nurses, health visitors and midwives have to cover patients of many practices) frequent redeployment of nurse manpower often proved unavoidable, sometimes at short notice. Furthermore the need to provide a nursing service to the whole community may require a degree of geographical nurse cover particularly in areas with high mobility of population.

6.8 As a result schemes of nurse attachment to general practices are increasingly being reviewed, and in the last two years or so a number of health authorities, particularly in urban areas, have reverted to a geographical pattern of working. This apparently major stumbling block to the further development of primary health care teams is being associated by some with the rigidity of nurse management which is said to take little account of the needs of individual primary health care teams and general practices.

6.9 To us this seems an oversimplification of the basic problem. Most general practitioners consider their independent contractor status sacrosanct. With this goes the separate, and to some extent isolated administration of general practitioner services, in England and Wales, through FPCs. Moreover, GPs can engage and employ practice nurses direct and outside the administration of the nursing services which are provided by health authorities. Small wonder, then, that there are clashes of interest between independent contractors whose prime interest must be for the patients on their practice list and nurse managers whose prime duty is to organise nursing services as effectively as possible for the whole population of a particular geographical area.

6.10 We believe that the absence of attachment does not necessarily exclude the possibility of teamwork, any more than the presence of an attachment scheme guarantees its existence. After study of much written and oral comment we are convinced that the concept of the primary health care team is viable and should be promoted wherever possible. It need hardly be said, however, that more is needed than the acceptance of a principle, and that successful teamwork needs more than a mutual agreement to work together. We are convinced that conscious efforts towards preparation for teamwork need to be made both at individual team level and, at least as important, during formative professional training, preferably on a multidisciplinary basis. We are impressed by the efforts which have been made to this end by enlightened doctors and nurses, and by their professional organisations working in close concord. But their task is more difficult when the primary health care team concept increasingly involves colleagues who are not necessarily inspired by a pioneering commitment from the out-set or who are not all experienced in the very wide range of skills needed to provide care in the community.

6.11 It is true that good personal relations and communications can modify difficulties, but we wish to stress again, as we have done in the body of our Report, that a causal association of difficulties experienced in the continuity of nurse staffing in primary health care teams with inflexibility on the part of senior nurses is a convenient oversimplification, especially when this is expressed by doctors, many of whom are only slowly becoming aware of the conflict between their traditional outlook as independent contractors with total responsibility for "their" patients and the need for inter-dependence in their relationships with other professionals contributing to the overall delivery of primary health care services.

6.12 We must also accept that there are circumstances which, at least for the time being, militate against exclusive or even large-scale delivery of primary health care on an integrated team basis. An extreme example is the present situation in declining urban areas, where there is a confluence of adverse factors, such as high mobility of population, small and often single-handed practices, large scale out-of-hours cover of general practice by deputising services and, indeed, a disinclination of professional workers to accept the primary health care team as the proper base for primary care.

6.13 We are not entirely surprised, in view of this, that many of the comments made to us expressed concern about the future of teamwork. The potential impact of the difficulties arising out of lack of resources, the separation between the structures of general medical and nursing services, and social aspects of inner cities is obvious. And if our Report presents an adequate description of the scope and seriousness of these difficulties, as we believe it does, this in itself may help staff at local level to realise the need for flexibility in their arrangements for liaison and co-operation to enable them to be overcome.

6.14 We also consider it important to stress the implications of pessimism about the future of teamwork. These would almost certainly include the loss to the patient of the benefits of comprehensive and continuous care and a general reduction in personal fulfilment and satisfaction for the staff involved. At a time when the advantages of providing care in the patient's home whenever possible are increasingly apparent, it is vital for primary health care services to be provided on a comprehensive and co-ordinated basis.

The Wider Team

6.15 Although our attention has been confined to consideration of the "core team" of general practitioners, district nurses, midwives and health visitors together with secretaries/receptionists and practice nurses, we were conscious throughout of the value of the extended team which can provide the patient with access to wider professional skills within an integrated and co-ordinated framework and act as a focal point in the community for the provision of primary health care. This wider team can include the provision of dental and pharmaceutical services and the association of members of some professions supplementary to medicine, such as chiropodists and physiotherapists. Similarly, primary health care teams can provide convenient bases for collaboration between the "core team" and some consultants, especially in the fields of child health, geriatrics, mental health and obstetrics. We also recognise the need for close liaison between the primary health care team and other teams or groups of professionals providing for the needs of particular groups of patients; eg children, the mentally ill and the mentally handicapped; and similarly we acknowledge the great merits of associating social workers with primary health care teams. The remit of our working group, its composition and the urgency of our task in relation to the "core team" unfortunately prevented us from giving full consideration to this, and, in any case, present manpower problems in the local authorities' social services militate against a substantial increase in the frequency of such association in the foreseeable future.

The Future

6.16 Looking to the future, we consider that the continued spread of effective teamworking is very important if the primary health care services are to be able to meet the challenge posed by the predicted demographic changes within our population, coupled with radical changes in treatment policy, some of which are already increasing the pressure on primary health care services. Further progress largely depends on a general acceptance of a number of basic points. These include:

- i. absence of attachment need not prevent the development of effective teamwork although we acknowledge that attachment schemes remain by far the simplest way of promoting the close liaison and commonality of objectives which lead to integrated co-operation between professional staff in different health service disciplines;
- ii. nursing services must be organised in the way that most effectively reconciles the need to promote teamwork with the need to provide adequate nursing services to the total population within a given geographical area;
- iii. health authorities, particularly those most closely concerned with providing primary health care services, must actively strive to integrate the planning and organisation of FPC and health authority-provided services, particularly in the light of the Government's present plans for restructuring the NHS which seem likely to increase the problems of separation of services at operational management level;

- iv. the concept of teamwork needs to be actively promoted through continued training at all levels, particularly within a multidisciplinary frame-work; and
 - v. there must be a commitment to the principle of teamwork at local level by all the professional staff involved.
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CHAPTER 7 - SUMMARY OF RECOMMENDATIONS

Financial and staffing resources (paragraph 2.11):

1. the target ratios of health visitors and district nurses to population should be up-dated to take account of changes in working hours, holiday entitlement, training requirements, etc;
2. all authorities with ratios below the old targets should be encouraged to increase their staffing to this level as soon as possible;
3. those authorities with "Inner City" problems should take urgent action to reach the ratios suggested for areas with particular problems;
4. continued priority should be given to expanding health visiting and district nursing services; and
5. no further closures of or restrictions on in-patient facilities, or the introduction of a new early-discharge policy, should be undertaken without consideration of and consultation about the likely consequences for primary health care services.

Premises (paragraph 2.17):

6. the eventual users of primary health care should be consulted during the initial design stages of new premises and be represented on the Project Team;
7. all new or adapted practice premises should be of sufficient size to accommodate the members of the team and their anticipated activities;
8. new or adapted premises should be designed wherever possible to facilitate informal contact between team members; and
9. any revision of the Building Note on Health Centres should take account of our comments in respect of the size and design of the facilities that should be provided and it should so far as possible be sufficiently broadly based to provide guidance on the design of group practice premises.

Deployment of Staff (paragraph 2.22)

10. health authorities should, as soon as possible, make arrangements to provide night and weekend nursing services where these are not already in existence.
11. research should be conducted into levels of patient-dependence on nursing services in the community in relation to the various levels of nursing skills and experience available in primary health care teams;
12. until the results of such studies are available, senior nurses should conduct continuing appraisals of the mixture of trained and support staff within nursing teams in the community.

13. in order to facilitate the planning and management of nursing services in the community, FPCs should make available relevant data about practice size, number of persons on lists living outside the health authority boundary etc to the appropriate nurse administrator on a strictly restricted and confidential basis; and

14. adequate clerical support should be provided for district nurses, health visitors and midwives.

Patients' records (paragraph 2.26)

15. all team members should generally have access to records kept by other members of the team; and

16. each team should review its need for particular types of practice register, and where necessary, co-operate to assemble and organise, on a confidential basis within the team, data identifying patients in the practice who are in groups requiring special health surveillance.

Financial management (paragraph 2.31):

17. the DHSS should negotiate a national agreement with the GMSC by which expenses attributable to AHA-employed nurses working in premises owned or rented by the GP can be reimbursed to the GP by the health authority.

Medical and nursing training (paragraph 3.8)

18. multi-disciplinary education in primary health care should be included in post-graduate and post-basic courses, as part of their examined component;

19. preparatory training for teamwork should be included in under-graduate medical and basic nursing education; and

20. the value of experienced primary health care teams in providing a potential focus for widening practical experience of and training in teamwork at all levels should be more widely recognised.

Practice nurses (paragraph 3.14):

21. the Department, the GMSC and nursing organisations should consider the role of the practice nurse, her relationship with health authority employed nurses, and her need for training;

22. in the longer term, health authorities should make sufficient resources available to enable these nurses to be employed within the normal NHS structure in a fully integrated nursing service without prejudice to existing arrangements where these are working satisfactorily; and

23. constraints which place limits on the range of duties which health authority employed nurses may undertake should be subject to periodic review by health authorities in consultation with IMCs, along with any other factors which might prevent attached nursing staff working alongside GPs in surgery-based treatment rooms.

Receptionists' and secretaries' training (paragraph 3.17):

24. greater efforts should be made to encourage receptionists and secretaries to undergo training specifically oriented towards work in primary health care and the existing arrangements for reimbursing the costs associated with such training to GPs should receive wider publicity.

Communications and management of services (paragraph 4.8, 4.16, 4.25 4.28 and 4.31):

25. whenever changes in deployment of nurses are impending, the appropriate senior nurse should always ensure that all who are substantially concerned with the working of the team are adequately informed (paragraph 4.8);

26. senior nurses, GPs and attached nurses and health visitors should take advantage of opportunities to strengthen and improve informal liaison and communication links (paragraph 4.16);

27. health authorities should only select nurses with considerable experience in the primary health care field for appointment to nurse management posts closely involved with primary health care (paragraph 4.16);

28. more opportunities should be provided for joint management training for GPs and senior nurses with primary health care responsibilities (paragraph 4.16);

29. the Government and health authorities should seek to ensure that the proposed changes in the management structure of the NHS strengthen the effectiveness of the management of primary health care services by taking account of the fact that management considerations in the community are often different from those relevant to hospital management. It should also recognise and avert the risk of strengthening hospital management at the expense of reducing the effectiveness of the management of health services in the community (paragraph 4.16);

30. health authorities and LMCs should consider whether liaison arrangements between primary health care teams and child health clinics are adequate, and if they are not, should take steps to improve them (paragraph 4.25);

31. community physicians should become more closely involved in primary health care team activity especially in the planning of preventive and health education programmes (paragraph 4.25);

32. the existing arrangements for liaison between community midwives and primary health care teams should be reviewed carefully and senior midwives should take steps to improve them where necessary (paragraph 4.28);

33. all premises used by primary health care teams should have adequate space for meetings of the full team and be designed to facilitate and encourage informal day-to-day contact between team members (paragraph 4.31);

34. all team members should agree procedures to ensure that their colleagues can easily contact them when necessary (paragraph 4.31); and

35. improvements in communication systems should be actively pursued wherever they can be cost-effective (paragraph 4.31).

Organisational factors including attachment arrangements
(paragraphs 4.37 and 4.44):

36. where it is thought that zoning the areas served by group practices might make for easier formation of primary health care teams, LMCs should examine existing arrangements to see whether agreement could be reached by the GPs concerned voluntarily to limit, or zone, areas served by the different group practices and/or partnerships. This should be done in close consultation with CHCs to ensure that patients' freedom of choice of GP is not significantly reduced (paragraph 4.37); and

37. health authorities in consultation with LMCs should review existing arrangements including attachments to ensure that they facilitate teamwork in the provision of primary health care services. All those involved in such a review should adopt a flexible approach and recognise the need to preserve what already works well in the patients' interest. (paragraph 4.44).

Rural areas (paragraph 5.4):

38. health authorities should recognise that the problems of sparsely populated rural areas may make the provision of primary health care services more expensive pro-rata than the provision of such services in urban areas, but that this additional expense must be accepted as the price of providing a comprehensive service to the community as a whole;

39. reciprocal arrangements in relation to the provision of district nursing and health visiting services between health authorities where large GP practices overlap authority boundaries should be negotiated; and

40. the possibility of encouraging voluntary zoning of GP practices to reduce the overall amount of travelling necessary should be considered by LMCs in consultation with CHCs.

Declining urban areas (paragraph 5.13):

41. encouragement should be given to those medical schools in inner cities which have not already done so, to introduce adequately-resourced academic Departments of General Practice, and existing University Departments of General Practice in inner cities should strengthen and extend their links with local GPs and primary health care teams;

42. the Secretary of State should make use of his powers under Section 10 of the NHS Act 1966 and Section 56 of the NHS Act 1977 to enable health authorities to employ salaried GPs, wherever possible in association with University Departments of General Practice, in declining urban areas where alternative attempts to recruit new GPs prove fruitless;

43. measures to improve the quality of general medical services provided in declining urban areas should be introduced. These should include arrangements to encourage earlier voluntary retirement of elderly GPs with small lists. Such lists should not be advertised as practice vacancies, but should either be absorbed by neighbouring group practices which should be allowed to increase the number of partners as necessary, or contribute to the formation of a new group practice. In addition such measures might also include investigation of the possibility of those GPs already working in group practices and partnerships voluntarily agreeing to limit, or zone, their practice areas and a review of MPC procedures to encourage the appointment of GPs likely to be favourably disposed towards the idea of teamwork.

44. measures to improve the quality of practice premises in declining urban areas, including providing help to GPs to expand or otherwise improve their practice premises to provide a base for a primary health care team, should be pursued, and where appropriate, given more publicity;
45. the General Practice Finance Corporation, in exercising its extended powers under Section 17 of the Health Services Act 1980 to buy and lease back practice premises to GPs, should give priority to the improvement of practice premises in declining urban areas;
46. where GPs who are in unsatisfactory premises which do not lend themselves to improvement wish to be accommodated in health centres, health authorities in declining urban areas should give priority to their provision;
47. where recruitment of successors to single-handed GPs working in declining urban areas is going to be difficult unless the opportunity of working in a primary health care team from suitable premises can be offered, health authorities should consider building a health centre in advance of need;
48. positive discrimination should be exercised in relation to health visitor and district nurse staffing in declining urban areas, and further fact-finding and operational studies should be carried out with a view to establishing how recruitment and continuity of service can best be encouraged;
49. to that end the possibility of providing housing at a reasonable rental including the use of accommodation in hospitals no longer required by hospital staff should be pursued; and
50. health authorities in declining urban areas should concentrate training resources on training more mature nurses, and should provide, where appropriate, part-time courses for nurses with domestic commitments.
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ANNEX 1 - LIST OF THOSE WHO SUBMITTED EVIDENCE TO THE JOINT WORKING GROUP

1. ORAL EVIDENCE

*Dame Elizabeth Ackroyd - Chairman, Patients' Association

Dr J G Beales - Research Fellow, Department of Rheumatology, University of Manchester (formerly Research Fellow in the Organizational Analysis Research Unit, University of Bradford).

Miss J Calder - Divisional Nursing Officer (Community) North West HD(T), Kensington Chelsea and Westminster AHA(T).

Dr Ann Cartwright - Director, Institute for Social Studies in Medical Care.

Dr Irene Chesham - Specialist in Community Medicine (Child Health), Cheshire AHA.

Dr G M Coleman - General practitioner, Birmingham and member of W Birmingham District Management Team.

Mrs M J Davis - District Nursing Officer, Guy's Health District, Lambeth, Southwark and Lewisham AHA(T).

Dr V W M Drury - General practitioner and senior clinical tutor in General Practice, Birmingham.

Dr Arnold Elliott - General practitioner, NE London.

Miss A Grey - Divisional Nursing Officer (Community), Canterbury and Thanet Health District.

*Dr Rosemary Graham - Specialist in Community Medicine (Child Health), Merton, Sutton and Wandsworth AHA(T).

Miss H Holmes - Health Visitor, Birmingham.

*Dr Lisbeth Hockey - Director of Research Unit, Department of Nursing Studies, University of Edinburgh.

Miss J Hubbard - Area Nursing Officer, Birmingham AHA(T).

*Dr B Jarman - General practitioner, Inner London.

Mrs Jennings - Nursing Officer (Community), Tunbridge Wells Health District.

Mrs M Kerswill - Area Nurse (Child Health) Greenwich and Bexley AHA.

Miss D O Learmont - Nursing Officer (Children's Services), DHSS.

Miss A P Little - Area Nursing Officer, City and E London AHA(T).

Miss M McCaffrey - Divisional Nursing Officer (Community), N, Birmingham Health District.

Mrs E D Maxted	- Area Nurse (Child Health), Bromley AHA.
Dr W Nicol	- Area Medical Officer, Birmingham AHA(T).
*Dr J M Oldroyd	- Secretary, Inner London Local Medical Committees.
*Dr R Ottoway	- Lecturer, University of Manchester, Institute of Science and Technology.
Miss M Pilbeam	- Area Nursing Officer, East Sussex AHA.
Miss G M Pittom	- Area Nursing Officer, Redbridge and Waltham Forest AHA.
*Dr P M M Pritchard	- Lecturer, Department of Social and Administrative Studies, Oxford University.
*Dr B L E C Reedy	- Senior Lecturer in the Organisation of Health Care, University of Newcastle-upon-Tyne.
*Miss J Roberts	- Health Economist, London School of Hygiene and Tropical Medicine.
Dr C Taylor	- General practitioner, Liverpool and formerly member of the Royal Commission on the NHS.
*Mr R Toulmin	- Assistant Secretary, Children's Division, DHSS.
Dr C J Wells	- General practitioner, Sheffield and formerly member of the Royal Commission on the NHS.
*Professor E Wilkes	- Professor of Community Care and General Practice, Department of Community Medicine, Sheffield University Medical School.
Mr C H Wilson	- Assistant Secretary, Personnel Division, DHSS.
*Also submitted written comments	

2. WRITTEN EVIDENCE

i. Professional Organisations

Association of Medical Secretaries

British Psychological Society

Council for the Education and Training of Health Visitors

General Medical Services Committee of the British Medical Association

Health Visitors' Association

National Conference of Postgraduate Advisers in General Practice

Panel of Assessors for District Nursing Training

Royal College of General Practitioners

Royal College of Midwives

Royal College of Nursing

Royal College of Obstetricians and Gynaecologists
Royal College of Psychiatrists
Society of Family Practitioner Committees

ii. Regional Health Authorities

Yorkshire RHA

Trent RHA

North West Thames RHA

West Midlands RHA

North Western RHA

Regional Nursing Officers submitted consolidated comments
co-ordinated by Miss O E Senior, Regional Nursing Officer,
Trent RHA.

iii. Area Health Authorities, Health Districts and Welsh
Health Authorities

Northern

Cleveland AHA

N Tyneside AHA

Cumbria AHA

S Tyneside AHA

Yorkshire

Calderdale AHA

N Yorkshire AHA

Humberside AHA

Wakefield AHA

Leeds AHA(T)

Trent

Derbyshire AHA

Lincolnshire AHA

Leicestershire AHA(T)+

Nottinghamshire AHA(T)

East Anglia

Cambridgeshire AHA(T)

Suffolk AHA

Norfolk AHA*

N W Thames

Barnet AHA

North Bedfordshire Health
District*

Brent and Harrow AHA

N E Thames

Barking and Havering AHA	Essex AHA
Camden and Islington AHA(T)	West Roding Health District
Enfield and Haringey AHA	

S E Thames

East Sussex AHA	Kent AHA*
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S W Thames

Croydon AHA*	Surrey AHA*
Merton, Sutton and Wandsworth AHA(T)	West Sussex AHA

Wessex

Hampshire AHA(T)	Wiltshire AHA
Isle of Wight AHA	Winchester and Central Hampshire Health District

Oxford

Berkshire AHA*	Northamptonshire AHA*
Buckinghamshire AHA*	Oxfordshire AHA(T)

South Western

Avon AHA(T)*	Devon AHA
Bristol Health District (Teaching)*	Gloucestershire AHA*

West Midlands

Coventry AHA	Staffordshire AHA
Salop AHA	Wolverhampton AHA
Solihull AHA	

North Western

Blackpool Health District	Ormskirk Health District+
Bolton AHA	Preston Health District
Lancaster Health District	Rochdale AHA
Oldham AHA*	Wigan AHA

Wales

Clwyd Health Authority	Powys Health Authority
Gwent Health Authority	South Glamorgan Health Authority
Gwynedd Health Authority*	West Glamorgan Health Authority

NOTES *Entirely nursing staff comments. +Entirely medical staff/GP comments.
A number of comments incorporated comments from other bodies (eg LMCs) not part of the AHA.
Humberside, Hampshire and Merton, Sutton and Wandsworth AHA also provided detailed information in response to the pilot questionnaire.

iv. Family Practitioner Committees and Local Medical Committees

Greenwich and Bexley FPC

Kensington, Chelsea and Westminster FPC

Hampshire LMC

Merton, Sutton and Wandsworth LMC

Staffordshire LMC

Stockport LMC

} Took part in the pilot
questionnaire survey

Exeter District sub-committee of Devon LMC

v. Community Health Councils

Aberconwy CHC

Beverley CHC

Bexley CHC

Bury CHC

Central Birmingham CHC

Chichester CHC

Coventry CHC

East Hertfordshire CHC

North Devon CHC

North Hammersmith and Acton CHC

Portsmouth and South East Hampshire CHC

Sefton Northern CHC

Southampton and South West Hampshire CHC

South Bedfordshire CHC

South Gwent CHC

South Tees CHC

Sutton and West Merton CHC

vi. Individual Correspondents

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- General Practitioner, Kidderminster.

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- Research Fellow, Health Services.
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Dr N H Barley

- General Practitioner, SW London.

Dr A M Bateman

- General Practitioner, Cambridge.

Ms D S Beer

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G H Bellis

- Nursing Officer, Kensington, Chelsea
and Westminster AHA.

J M Bevan	- Assistant Director Health Services Research Unit, University of Kent at Canterbury
Dr J A Bochsler	- General Practitioner, SE London.
Dr C J Booth	- General Practitioner, Reading.
Miss J Byatt	- Area Nursing Officer, Hillingdon AHA.
Dr R A Clay	- District Community Physician, East Roding Health District.
Dr A S Cullen	- General Practitioner, Glasgow.
Professor R Harvard Davis	- Director of General Practice Unit, Welsh National School of Medicine.
Dr D Gau	- Senior Lecturer in General Practice, Middlesex Hospital Medical School.
Dr J H Gay	- General Practitioner, Essex.
Dr C R Hart	- General Practitioner, Peterborough.
Mrs A Hendy	- Senior Lecturer in Health Visiting, Bolton Institute of Technology.
Dr R C Humphries	- General Practitioner, Powys.
Ms Joyce Jameson	- Senior Lecturer in Health Visiting, West London Insitute of Higher Education.
Dr S A P Jenkins	- General Practitioner and member of North Western RHA.
Dr M Johnston	- Lecturer in Clinical Psychology, University of London.
Dr S E Josse	- Regional Adviser in General Practice NE Thames RHA.
Dr A Lask	- Clinical Assistant, Friern Hospital, N London.
Professor R F L Logan	- Director of Medical Care Research Unit, London School of Hygiene and Tropical Medicine.
Dr B W McGuinness	- General Practitioner, Cheshire.
Dr P G Mann	- General Practitioner, Bolton.
Dr G N Marsh	- General Practitioner, Stockton-upon-Tees.
Professor D Metcalfe	- Head of Department of General Practice, Manchester University Medical School.
Ms A A Moorfield	- Health Visitor, Warrington.
Dr G Mulholland	- General Practitioner, Dorset.
Dr R Pietroni	- General Practitioner, SE London.
Dr J Price	- General Practitioner, Hampshire.
Dr J Roberts	- Regional Adviser in General Practice, North Western RHA.

Ms J Robinson	- Health Visitor, Newcastle-under-Lyme.
Dr R M Ridsdill Smith	- General Practitioner, Kent.
Dr J W Soper	- General Practitioner, Lymington.
Mrs M M Storey	- Community Midwife, Durham.
Ms A E Stowers	- Nursing Officer (Health Visiting) Halifax.
Dr Gillian Strube	- General Practitioner, Crawley.
Dr W M Styles	- General Practitioner, Central London and member of N Hammersmith District Management Team.
Dr S W Waydenfeld	- General Practitioner, N London.
Dr C R Whitehouse	- General Practitioner, Manchester.
Dr D L Williams	- General Practitioner, Clwyd.
Mrs H R Winn	- Divisional Nursing Officer (Community) S Warwickshire Health District.
Dr S J Wright	- General Practitioner, Sheffield.

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ANNEX 3 - MULTIDISCIPLINARY TRAINING COURSES

This list is not comprehensive or exhaustive, merely listing courses brought to our attention by those providing evidence to the Group.

Regular multidisciplinary training courses

Aberdeen University in association with Bell College of Technology
Aberdeen University in association with Robert Gordon's Institute of Technology.

Brighton Polytechnic

Bristol University

Bolton Institute of Technology

Croydon College

Glasgow College of Technology

Hull University

Keele University

Liverpool University

Mid-Kent College of Higher and Further Education

Milton Keynes College of Education

North London Polytechnic

Paisley College of technology

Southampton University

South Bank Polytechnic, London

Suffolk College of Higher and Further Education, Ipswich

Teeside Polytechnic

Trent Polytechnic

West London Institute of Higher Education (ex Chiswick) College

Thamesmead Interdisciplinary Project

Management Training Courses sponsored by the DHSS under the auspices of the National Training Council at a number of Universities, Polytechnics and Business Schools.

There have also been a considerable number of "one-off" multidisciplinary seminars and short courses over the last 10 years or so, including courses organised by health authorities, professional organisations such as the Council for the Education and Training of Health Visitors, and other bodies including the King Edward's Hospital Fund for England and Wales and the Nuffield Hospitals Trust.

ANNEX 4 - LIST OF ABBREVIATIONS USED IN REPORT

AHA	-	Area Health Authority
AHA(T)	-	Area Health Authority (Teaching)
AMS	-	Association of Medical Secretaries
CETHV	-	Council for the Education and Training of Health Visitors
CHC	-	Community Health Council
CSSD	-	Central Sterile Supply Department
DESS	-	Department of Health and Social Security
FPC	-	Family Practitioner Committee
FPS	-	Family Practitioner Services
GMSC	-	General Medical Services Committee
GP	-	General Practitioner
HD(T)	-	Health District (Teaching)
LMC	-	Local Medical Committee
LHA	-	Local Health Authority
MPC	-	Medical Practices Committee
NHS	-	National Health Service
OPCS	-	Office of Population Censuses and Surveys
RCGP	-	Royal College of General Practitioners
RHA	-	Regional Health Authority
SMAC	-	Standing Medical Advisory Committee
SNMAC	-	Standing Nursing and Midwifery Advisory Committee
SEN	-	State Enrolled Nurse
SRN	-	State Registered Nurse
UK	-	United Kingdom
WTE	-	Whole time equivalent.

NEWCASTLE AREA HEALTH
AUTHORITY (TEACHING)

12 JUN 1981

COMMUNITY HEALTH SERVICES

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